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COMMISSION OF INQUIRY  
INTO THE  
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE  
SUR L'USAGE DES DROGUES  
A DES FINS NON MEDICALES

October 23, 1970

Queen Elizabeth High School,  
HALIFAX, Nova Scotia







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BEFORE:

- Gerald LeDain, Chairman
- Marie-Andree Bertrand, Member
- Ian Campbell, Member
- J. Peter Stein, Member
- H. E. Lehmann, M.D., Member

EXECUTIVE-SECRETARY

James J. Moore

SECRETARY TO THE CHAIRMAN:

Vivian Luscombe

October 23, 1970

Queen Elizabeth High School,  
HALIFAX, Nova Scotia.





Halifax, Nova Scotia

October 23, 1970

---Upon commencing at 9:30 a.m.

THE CHAIRMAN: Ladies and gentlemen, I declare this hearing of the Commission of the Inquiry into the Non-Medical Use of Drugs open, and I would like to express our satisfaction at having the opportunity of visiting Halifax. I feel the last time we had a most helpful hearing in this city, and we are back now to get the benefit of your reactions to the Interim Report, and other views that you may have formed in the interval on the subject matter of our Inquiry.

Perhaps it is not necessary to dwell at any length on the terms of reference, but a brief reminder of them might be helpful this morning. We were appointed on May 29th, 1969 with a two year mandate to inquire into mainly three things: the effects of non-medical drug use, of psychotropic and mood modifying substances; the extent and patterns of the use in Canada and the causes of the use, and more broadly, the social context of the use, the meaning of non-medical drug use in the society today, and the significance. And on the basis of our findings on these three issues, we are required to make recommendations to the Federal Government as to what it can do alone or with other levels of Government, and I use the words in our terms of reference, "to reduce the dimensions of the problems involved in such use". We were required, as you know, to submit an interim report and this we did at the end of May of this year, which was made public, and we are now in the second phase of our inquiry and we are working on





1 our final report which we have been asked to submit by  
2 the end of May, 1971. The Interim Report was conceived  
3 and drafted and as a document which might serve as a  
4 basis for further consideration and discussion by the  
5 people of Canada, and we are anxious to have the benefit  
6 of your reflections on it. It also is intended to  
7 indicate what we, at an interim stage, conceive to be  
8 the issues and relationship. We also intended to  
9 disclose as much as we had at that time, and also our  
10 own perspective, our own approach to the issues; some  
11 of what you might call our hypotheses. And also we  
12 attempted to indicate the areas into which we wanted to  
13 do further study before we felt able to make recommenda-  
14 tions. And we attempted to indicate in the report, we  
15 see this problem as a large one to call for a mountain  
16 of social responses of which law is only one, and  
17 which includes such other things as research, information,  
18 education, treatment, after care and other initiatives,  
19 personal and corporate to remove the social conditions  
20 and aspects of our personal relations, which encourage  
21 non-medical drug use. So really we are seeking a wide  
22 social response, we are seeking wisdom and we are still  
23 very much convinced we have to have as much contact as  
24 we can with the people in Canada in their various  
25 relationships to this phenomenon, because that is  
26 where the sense of social feasibility and social wisdom  
27 must, in the final analysis, lie in the sense of what  
28 we can expect to accomplish with the various responses,  
29 sense of what are the limitations of the various  
30 responses, and responsibilities.





1                   So we would welcome not just the views  
2 of those who have been good enough to come with  
3 prepared submissions today, but also of all present,  
4 and we have set microphones, as you will see, in the  
5 aisles here and you should feel very free to give us  
6 the benefit of your views. We will follow the  
7 procedure such as we did before. We will hear the  
8 scheduled submissions and at the end of each there will  
9 be an opportunity for comment, both by the Commission  
10 and all present.

11                   I trust that is sufficient by way of  
12 introduction, and I should just like to introduce the  
13 members of the Commission who are present today: on my  
14 far right, Dean Ian Campbell of Montreal; on my  
15 immediate right, Dr. Heinz Lehmann of Montreal; I am  
16 Gerald LeDain; on my left, Mr. James Moore, Executive  
17 Secretary of the Commission; on Mr. Moore's left,  
18 Professor Marie-Andree Bertrand of Montreal and on Miss  
19 Bertrand's left, Mr. J. Peter Stein of Vancouver.

20                   Now I believe we have a submission from  
21 Dr. Mark Segal, Department of Pharmacology, Dalhousie  
22 University.

23                   If I may, Dr. Segal, I should just make  
24 an observation of television here. In the first stage  
25 of our inquiry we made a decision that our hearings  
26 should not be televised. We felt that that might  
27 inhibit discussion because of the nature of the  
28 subject matter and rather intimate nature of some of  
29 the information that might be conveyed to us in our  
30 hearings. We stuck with that policy. And then towards





1 the end of our hearings, we were asked and it was said  
2 to us, "It is in the public interest this be exposed and  
3 there be an audio-visual record of how you have gone  
4 about your business"and we finally conceded with some  
5 reservations to that requested in Hamilton, and in  
6 Hamilton at one of our hearings there, we allowed  
7 televising of the hearing. This did not seem to  
8 inhibit us --- it did not seem to inhibit discussion.  
9 However, we still had this concern. Now when we  
10 started out again on this last series of hearings, seeking  
11 response to the Interim Report, it was impressed upon  
12 us that it was perhaps in the public interest that there  
13 be an opportunity for wide access to the hearing and to  
14 views expressed in the hearing, and that people who are  
15 unable for one reason or another to be present, ought  
16 to be able to hear what was said, and thus there would  
17 be a greater response and understanding from the public,  
18 of the hearing itself, and we concluded that this  
19 was sound and reasonable since we were only going to be  
20 in one city in each province. Now at the same time, we  
21 still are concerned about people who do not wish to  
22 be identified here, although they are making a statement  
23 in public --- this is of course public --- nevertheless  
24 they do not wish to be televised, and the cameramen here  
25 this morning have agreed not to take a picture of  
26 anyone who, at the time they wish to speak into the  
27 microphone--it is merely sufficient to indicate that  
28 you do not wish to be photographed, and if you would  
29 just indicate that with your hand in that manner, the  
30 television cameramen will stop the film and at least





1 will not take a picture of you. Now, as you know, our  
2 public hearings are only one of our methods of inquiry,  
3 and we do receive and are able to receive testimony  
4 privately and anonymously and therefore we do not expect  
5 in the public hearing --- we certainly do not wish  
6 people to say anything which might, or they might think  
7 would incriminate them. We are seeking general views  
8 resulting from knowledge and experience, and not  
9 attempting --- we do not seek to identify the experience  
10 of any particular individual.

11 Many people all across Canada have  
12 availed themselves, giving their testimony anonymously  
13 and privately, and of course it is kept very carefully.  
14 There is no particular privilege for testimony given  
15 in public. I just want to say concern has been  
16 expressed from time to time about whether our hearings  
17 might be used or exploited for law enforcement purposes,  
18 and when we started out the Inquiry, I sought assurance  
19 and received assurance that they would not, or this  
20 would not be done, and although concern has been  
21 expressed from time to time as to whether in fact there  
22 would be any testimony used for law enforcement purposes,  
23 although I have repeatedly asked any such evidence be  
24 brought to my attention, and I would take it up at the  
25 highest level, we have received no such evidence. We  
26 have every reason to believe that that undertaking has  
27 been respected, and I certainly never have doubted it  
28 from the level with respect to which it was given. But  
29 we have every reason to assume this. But I still repeat  
30 what I have said, and if I have any reason to believe





1 the contrary, of course I would take a most serious view  
2 of the matter, and this is well known, and take it up  
3 at the proper level. So that television cameras will  
4 record our hearing, but anyone who does not wish to be  
5 photographed may simply indicate that by passing their  
6 hand like that before they speak.

7 Now, Dr. Segal.

8 DR. SEGAL: As the Commission knows, this  
9 is the second brief to be presented by myself in a  
10 period of about eight months. The following statements  
11 about to be made and views presented do not necessarily  
12 represent those of my colleagues at Dalhousie University  
13 within the Faculty of Medicine, or within the Department  
14 of Pharmacology or of the other members of the Canadian  
15 Medical Association. I have ten comments I wish to  
16 make: "The Canadian Government must realistically  
17 begin to consider drug law reform, exert positive  
18 constructive efforts against pollution, bigotry, racism,  
19 regional economic disparity and begin to institute  
20 constructive policies of incorporating youth into  
21 structure of Canadian society if there is to be any  
22 expectation of creating a society healthier than our  
23 present one. Such a statement is easy to make, but  
24 can it be done? Everyone is working towards an improved  
25 technology. An advanced technology may even be  
26 required for a better life style, but has anyone truly  
27 evaluated our recent progress in technology and deter-  
28 mined what it has added towards a true gut happiness?  
29 Technology has allowed us to obtain milk in cardboard  
30 cartons, food out of cans and in general it has altered





1 the taste of the food we eat. It has also altered our  
2 environment, it dictates the way in which we live and  
3 determines our basic needs down to the point of telling  
4 us what to take for every ache, pain or discomfort.  
5 Our technological society has created a pollution of  
6 human relations that exceeds the pollution of the  
7 environment. There will be little chance of stemming  
8 the tide of a decaying environment if nothing is done to  
9 rebuild basic human relations. Our advanced society  
10 has forgotten that its youth is a part of the society.  
11 A recent survey in one part of Canada was conducted to  
12 determine whether the talents, energies and enthusiasm  
13 of youth could be utilized within established corpora-  
14 tions and institutions. The results were devastating -  
15 'we are sympathetic with your cause, but we really  
16 cannot use them'. Society honestly does not know what  
17 to do with its youth. It fears them and tries to  
18 categorize them into a specific and separate niche. If  
19 established orders were to incorporate youth, I fear it  
20 would only be to try and brainwash them to see the light  
21 of the established way. Adults scream that they not  
22 longer control their youth, yet when youth ask entrance  
23 into adult society, adult society will only agree on an  
24 acceptance on its own terms. Can anyone really wonder  
25 why youth not only want, but are presently forming  
26 their own society?

27 2. The problem defined by society as  
28 drug use or drug abuse will not be resolved by any  
29 single measure dealing with laws, punishments or  
30 deterrents. Neither will drug abuse education programmes





1 nor drug warnings prevent people from using or abusing  
2 drugs in general. Those with the power and will to form  
3 what is defined as a just society will have to re-  
4 establish their priorities and financially back programmes  
5 established to involve youth within our established  
6 society. The aim of such a programme must be a mutual  
7 consent toward change, not to brainwash the youth to  
8 see the light of the established way. Programmes will  
9 also have to be developed within the school system to help  
10 an adolescent determine where he fits into this society.

11 3. Education programmes have to be  
12 developed within the school system to show the student  
13 the role played by drugs in a dynamic society. Any  
14 programme, however, related to drugs must be flexible  
15 and multi-levelled so as to present and allow for  
16 discussion or ever increasing amounts of information  
17 through the primary and secondary school system. The  
18 programme must be incorporated with other social,  
19 psychological and environmental information so as to  
20 allow the high school student the opportunity of dis-  
21 cussion and challenge and then finally come to his own  
22 conclusions and make his own decisions.

23 4. The plea for more research must be  
24 heeded, but to be absolutely realistic the type of  
25 research required to answer some of the outstanding  
26 questions on the chronic effects of cannabis and some  
27 of the other drugs listed under Schedule J of the Food  
28 and Drugs Act cannot be carried out under the existing  
29 law. The only way to determine the long range  
30 physiological, psychological and sociological effects





1 of cannabis in our western technological society is to  
2 study large segments of that society that use cannabis.  
3 Although there are numerous estimates of adult  
4 professional use of cannabis, this population is useless  
5 to scientific research as long as cannabis remains  
6 illegal. Therefore, the least that I could suggest  
7 would be the establishment of a five year moratorium  
8 for such research to be carried out with full government  
9 financial support, along with the technical support  
10 available within the Food and Drug Directorate. I must  
11 emphasize, however, that five years would not be a  
12 sufficiently long period to determine conclusively any  
13 potential physical danger of cannabis in large popula-  
14 tions. For examples of this we can look at the history  
15 of aspirin, phenacetin and tobacco. Such a moratorium  
16 would be tantamount to making marijuana legally  
17 available. Of course, certain restrictions would have  
18 to be arranged at the Federal, Provincial and Municipal  
19 levels of government concerning availability, quality  
20 control, and taxation, and certain procedures developed  
21 for its sale. Age restrictions might also have to be  
22 established as with alcohol. However, when age restric-  
23 tions are discussed, this must be done in the light of  
24 our present data on alcohol and marijuana use in the  
25 under 21-year age group.

26 5. The government must be persuaded not  
27 to enter into any international agreement on the control  
28 of psychotropic drugs prior to the final recommendations  
29 of the Commission. If the Government of Canada signs an  
30 international treaty at the Vienna Convention in January,



1 1971, this would not only undermine the credibility and  
2 utility of the Commission but it would greatly damage  
3 the credibility of the Government in the eyes of the  
4 Canadian public. Canadians must be made immediately  
5 aware that the Government now appears to be proceeding on  
6 an international course of action completely at odds  
7 with the recommendation outlined in the Commission's  
8 interim brief. This course of action is tending towards  
9 more controls and stricter laws. This is occurring in  
10 the face of statements made by the Government that no  
11 policy decisions would be finalized prior to full  
12 public debate. This strongly leads one to doubt the  
13 credibility of the Government on certain issues.

14 I would also entertain a plea to the  
15 media to abstain from publishing the results of  
16 scientific research as this only enhances the confusion  
17 and polarization of the readers. Scientific results  
18 belong in scientific journals to be argued and debated  
19 by qualified scientists.

20 6. Since LSD and other powerful psycho-  
21 chemicals are being used and so used by free choice,  
22 and research is continuing to discover new and better  
23 drugs to improve the memory, to improve the capacity  
24 to learn, and to enhance the ability with which we accept  
25 our environment, realistic measures must be taken to  
26 allow that segment of society who need or choose to use  
27 such drugs for one reason or another, the means of  
28 using them in a manner which would minimize any  
29 potential dangers existing. This is tantamount to saying  
30 that individuals should have the educated privilege of





1 choosing their complete life style. If however, the  
2 present law that severely restricts the use of these  
3 drugs is not altered or if laws are passed to limit  
4 LSD for research purposes only, thus abolishing its  
5 treatment potential in the hands of qualified specialists,  
6 as might well soon happen if Canada enters upon the  
7 international agreement early in 1971, then how will  
8 scientists and the medical profession ever be able to  
9 aid legislators and society in general in its policy  
10 decisions?

11 7. We are fast approaching a time when  
12 society might officially have to recognize the non-  
13 medical use of drugs beyond the use of alcohol and  
14 tobacco. If drugs (mood modifying or otherwise) are to  
15 be incorporated into our life style, educational  
16 programmes will have to teach the proper use of drugs  
17 under various conditions. A drug hierarchy representing  
18 differential degrees of potential harm to the individual  
19 and society will have to be formally recognized by the  
20 medical and law making professions so as to draft laws  
21 appropriate to prevalent situations.

22 8. Within the present system of legal  
23 control, however, there is an ever increasing need for  
24 analytical services to be readily available to provide  
25 data on what is actually being sold on the street. This  
26 information is required by the medical profession called  
27 in to treat acute cases and by the educator who will be  
28 called upon to instruct in drug oriented programmes.  
29 That the information might be used by the trafficker is  
30 secondary and probably most useful in maintaining a





1 quality supply of illicit drugs. The necessity for  
2 these analyses services must be stressed over and over  
3 again until the Government is moved to positive action.

4 9. Governments must redefine their  
5 priorities for financial involvement. Financial resources  
6 must be made available for treatment facilities when  
7 and if required. These facilities need not take on  
8 institutional qualities but must be made flexible to meet  
9 the needs of any problem which may come to the surface  
10 in different parts of the country. This will be  
11 directly dependent upon the type of drug use and its  
12 dynamic usage pattern across Canada. Such a flexible  
13 system will be required as long as the laws remain struc-  
14 tured and unchanged. If and when drug laws are  
15 modified, then firmer facilities can be established to  
16 maintain that period of partial stability.

17 10. If it is at all possible, I would  
18 like to see a portion of the Commission's final brief  
19 devoted to the pressures exerted upon it by economic,  
20 political and religious interests and also speculation  
21 as to the overall effect that such influences might have  
22 on the final outcome of their recommendations. If for  
23 nothing else, such a section would make the Canadian  
24 public aware of the manner in which policy decisions of  
25 national interest are influenced by vested interest."  
26 I thank you sir.

27 THE CHAIRMAN: Thank you, Dr. Segal.  
28 Any questions?

29 Miss Bertrand?

30 PROFESSOR BERTRAND: Would you kindly give some



1 more explanation of your proposed moratorium in relation  
2 to research --- point 5, I think.

3 DR. SEGAL: Well, what I am asking is  
4 under the existing law, the type of research that has  
5 been carried out is along the lines for acute and  
6 chronic toxicity, behavioural attitudes, behavioural  
7 alterations, but there is no flexibility as to attain  
8 the type of information that is required in the study  
9 of large societies. Right now in both the United States  
10 of America and Canada, you have numerous estimates on  
11 the use of cannabis by the population at large. Now  
12 this population comprises adults of all ages, profes-  
13 sionals, non professionals, school teachers, doctors,  
14 lawyers and these are individuals going on in every day  
15 life, performing their tasks in one way or another.  
16 The only way that these people could be gotten to is  
17 if there were a change in the structure to allow  
18 these people to come forth and talk freely about their  
19 individual use. Now the reason for five years or two  
20 years or three years --- this can be thrown in for any  
21 means. It is tantamount to saying that the laws should  
22 be changed to make marijuana available to society. If  
23 your liberated society is ever going to get the answer  
24 that they wish to get to outlast any of the prejudices  
25 that exist, is if it is available. Because the examples  
26 as given, aspirin, phenacetin, tobacco, took over fifty  
27 years before you had any long term or long range  
28 indication of what the crowning effects would be.

29 THE CHAIRMAN: Dr. Lehmann?

30 DR. LEHMANN: If such a moratorium would





1 be enacted and during the time the information would  
2 accrue, would only be made available to scientific  
3 bodies, as you point out in journals, would you --- it  
4 is conceivable or it sounds rather possible an  
5 assumption that the public in these five years would  
6 form its own opinions, not only form opinions, but  
7 crystallize definite convictions, particularly from  
8 these findings. And even if they were exposed to them,  
9 so --- and since according to your proposal, all of  
10 this is in good quality and standardized conditions,  
11 legislation would regulate, and if --- how would you  
12 consider the possibility to indicate afterwards? Suppose  
13 society would be devastated, would it be possible in  
14 your opinion to change your position, and convince the  
15 public which had formed its own decision in that time,  
16 that scientifically it could not be so good for them?  
17 You see what has happened with cigarettes and aspirin.

18 DR. SEGAL: Well, there is two aspects  
19 to this. First of all, the plea of not having scientific  
20 results published in the media is only specifically for  
21 the period of, let us say, now. Because with the  
22 prejudice that exists in the population, the media is  
23 arousing more frustration and anger and what else. What  
24 I am outlining would not happen over a five year  
25 moratorium. During a five year moratorium, you would  
26 have research going on and publishing in scientific  
27 journals. You would have to establish professional  
28 bodies of scientists and lay persons to try and evaluate  
29 this and make the public continually aware of what is  
30 going on across the nation.





1                   Second of all, okay, take a look at  
2 cigarettes and alcohol. You are talking about something  
3 being proved absolutely devastating, but I think you  
4 have to go a little bit further, what is meant by  
5 devastating; devastating to actual physical harm ---

6                   DR. LEHMANN: I just mentioned one  
7 possible extreme. I did not go on to what I think the  
8 results would be.

9                   DR. SEGAL: I do realize that. Well, one  
10 could look first of all at this society here that has  
11 been using cannabis for a long time. And under the  
12 conditions, we cannot tell if it is devastating or not,  
13 although we know that people are using marijuana in ever  
14 increasing amounts and in ever increasing numbers. There  
15 is no way to get at this. I am asking the question, how  
16 do you get at it? Do you just leave it lie, or do you  
17 do something about it? This is both youth and adults.  
18 As far as cigarettes are concerned, well, again it is  
19 up to the individual to make up his own mind. But  
20 again the individual is not really allowed to really  
21 make up his own mind, when you take a look at the media,  
22 the amount of money being spent that advertises how  
23 good cigarettes are for you, and that you are not a man  
24 if you do not smoke a certain type of cigarette. And  
25 on the other hand, the amount of money being spent by  
26 the Government on anti-cigarette campaigns, and then you  
27 wonder where the balance is. In response to some of  
28 your questions, you have got the use of drugs in a large  
29 society. The majority of people are taking an anti-drug  
30 stand and are focusing on drugs. What bothers me very



1 much is the resorting to punishment, laws and deterrents.  
2 One very good question came up a day or so ago. What  
3 should be the role of the teacher in drug abuse campaigns?  
4 My personal response was to be an exciting teacher in  
5 your classroom, dealing with the subjects that you are  
6 teaching. Make history alive like everything else. Try  
7 and make --- the public is asking for viable alternatives  
8 to the use of drugs. First of all, there may be viable  
9 alternatives to the use of drugs, but even if you  
10 produce all kinds of viable alternatives, the only  
11 thing that you would do would be to stress drug problems.  
12 You would not in any way wipe out the need for these  
13 drugs.

14 DR. LEHMANN: You didn't really answer  
15 my question: whether you would consider it possible  
16 to modify or change legislation once a moratorium has  
17 been acted on and has been in full force for five years.

18 DR. SEGAL: If at the end of five years,  
19 the results were to be found to be so devastating as to  
20 say that conclusively you would have evidence that  
21 cannabis use under certain conditions would cause  
22 chromosomal damage and you could definitely prove that  
23 you had something like thalidomide, then there would  
24 probably be less problem of reversing any decision. If  
25 after the end of five years, you could show that, well,  
26 maybe there was some interference with lung tissue,  
27 some general deterioration that mild, along the line of  
28 cigarettes or along the lines of alcohol, then there  
29 would be more of a problem, because you would be in  
30 the same state of affairs as you would be with alcohol





1 in the United States. And although you can show  
2 statistically during prohibition there was less alcohol  
3 use, and there was probably less deaths due to cirrhosis  
4 of the liver, that is not the question. The question is,  
5 was society prepared to pay the price for prohibition?  
6 Not, was it prepared to pay the price for any physical  
7 damage caused by alcohol?

8 DR. LEHMANN: That is a very crucial  
9 question, yes.

10 MR. STEIN: What is the basis of your  
11 conviction that the developing of a viable, as you put  
12 it, alternatives would, and I'm quoting it, "would in  
13 no way alter the use or abuse of drugs".

14 DR. SEGAL: It wouldn't stop the use or  
15 abuse of drugs.

16 MR. STEIN: Why would it not in any way  
17 alter the pattern?

18 DR. SEGAL: I said it would alter the  
19 pattern.

20 MR. STEIN: Would? You were talking about  
21 the fact that alternatives to drug use, the development  
22 of them, in your mind would in no way alter the pattern  
23 of the use or abuse of drugs. Why are you so convinced  
24 of that?

25 DR. SEGAL: If you had a Utopian society,  
26 you would still have a drug use. But the pattern of  
27 drug use in such a Utopian society would be much  
28 different than the pattern of drug use today. Because  
29 if you take a look at individuals that have viable  
30 alternatives, who live exciting life styles, and we use





1 drugs. We use certain drugs because we really enjoy  
2 them, and they don't ruin our lives, but we have learned  
3 how to, in an educated way, exist with the drugs that  
4 we have around us. So what I am saying is that to try  
5 and wipe out the non-medical use of drugs, I think is an  
6 unfeasible type of approach. If you had altered --- an  
7 altered society, and you had more viable alternatives,  
8 maybe there would be a lessening in what is called drug  
9 abuse. In my own definition of abuse, I mean any type  
10 of intoxicating drug: using it to the point where the  
11 individual is useless to himself or society, and it is  
12 not simply the use of a drug not prescribed by medical  
13 physicians. It is probably at this level you would get  
14 altered patterns. But again, there are arguments on  
15 both sides of this, because the Addiction Research  
16 Foundation has taken correlated evidence that if you  
17 reduce the availability of drugs, you have more people  
18 using them and more people abusing them, because it is  
19 continual. But this type of evidence is only valid in  
20 the type of existing society we have today. If we have  
21 an alternate society I'm not sure if that evidence would  
22 hold.

23 DR. LEHMANN: Just to try to understand  
24 that clearly. Your altered society would be what you  
25 also refer to as the Utopian society, where people  
26 would have exciting life styles. Now, they, as you said,  
27 would still use drugs but in an acceptable pattern. Now  
28 the unacceptable patterns would be, for instance, the  
29 ignorant use of drugs which is being observed now. These  
30 people would all know what they are doing. Also



1 unacceptable would be the self destructive use of drugs  
2 as some of these speed freaks are saying that, "Well,  
3 speed kills and I will be dead in two or three years", but  
4 that is probably what they want. And I expect there  
5 would also be the escape use of drugs, I suppose in your  
6 society?

7 DR. SEGAL: I wouldn't go so far as to  
8 bring in escape, because we use many types of escape.

9 THE CHAIRMAN: I was going to say the  
10 definition of use you made, the point where the individual  
11 is useless to himself and society; is that what would be  
12 the adverse effect? (inaudible)

13 DR. SEGAL: Because anyone who drinks  
14 alcohol to the point of once or two or three times a week  
15 couldn't be considered useless to himself or society.  
16 There are many functions or persons in society who do  
17 this.

18 THE CHAIRMAN: What about momentary or  
19 temporary impairment which prevents effective functioning?  
20 Why do you insist on continuing ---

21 DR. SEGAL: Momentary impairment?

22 THE CHAIRMAN: Yes.

23 DR. SEGAL: All you have to do is go to  
24 the drug store and buy any type of histamine or anti-  
25 histamine with no prescription, and take two or three of  
26 these to relieve the symptoms of a cold and you have  
27 temporary impairment too, in which you can get into a  
28 car and have an accident.

29 DR. LEHMANN: But that doesn't answer  
30 the question of what you consider to be abuse. In your





1 Utopian society, you would then include escape as one of  
2 the acceptable ones, yet there are quite a few physicians  
3 who for instance will advise people never to drink when  
4 they, as I say, need a drink, but only to drink when  
5 they feel, well, to enhance their pleasure perhaps, and  
6 sociability. In other words, to enhance their function-  
7 ing, not to temporarily get dead drunk and forget. But  
8 you would accept that as an acceptable drug use pattern?

9 DR. SEGAL: I would accept it as an  
10 acceptable drug use pattern, because right now we use  
11 many things as an escape and some things we use are more  
12 devastating than the use of drugs.

13 DR. LEHMANN: The fact we do use them  
14 doesn't mean it would be acceptable for the Utopian  
15 ideal society. You would accept it, though, in a  
16 better society?

17 DR. SEGAL: I would probably accept it  
18 in a better society.

19 THE CHAIRMAN: Dr. Segal, as I understood  
20 your proposal for a five year moratorium, for a trial  
21 period of legalization, it is recommended in order to  
22 permit effective research. Is that not the purpose of  
23 the recommendation?

24 DR. SEGAL: That is one.

25 THE CHAIRMAN: That is only one?

26 DR. SEGAL: That is only one.

27 THE CHAIRMAN: Because it was my  
28 understanding it was necessary for research on a large  
29 group of society, and I was going to ask why it would  
30 be essential to carry out such research, that that kind



1 of research not be carried out under the present condi-  
2 tions if the necessary permission was given. If there  
3 is in fact widespread use and the material and subject  
4 for research is there. Does it not simply require per-  
5 mission and suitable protection for the subject of this  
6 research to make possible the necessary research?

7 DR. SEGAL: Let's say I were to be a  
8 chronic smoker of cannabis, and I enjoyed smoking  
9 cannabis and in my position, somebody close to me or  
10 even far away from me happens to have permission to do  
11 a study where he is going to call upon my information,  
12 my background, my use of cannabis in my position and  
13 tries to guarantee to me immunity. Do you honestly  
14 think I am going to come forward with the existing laws,  
15 in jeopardy to my financial future and my family, to go  
16 into such a study?

17 PROFESSOR BERTRAND: So it is the researching  
18 of the effect of use you would like to be able to carry  
19 on with the assurance that the persons who actually take  
20 drugs illegally could come forward, and relay or describe  
21 their experience, with regard to the damage to them?  
22 But isn't it possible to carry out research, supposing  
23 the regulations for the researchers could be easier to  
24 go by. Isn't it possible to carry on research actually  
25 as to the effects of the drugs?

26 DR. SEGAL: It is all very beautiful to  
27 get the effects of the drugs, but I think society is  
28 more anxious and more frustrated by what the use of  
29 cannabis will do to that structured society. The only  
30 way you are going to see what cannabis does to the





1 structured society is to literally be prepared or be  
2 able to see those individuals within the structured  
3 society who are using cannabis. If you are studying  
4 the effects of cannabis on the specific and physiological  
5 aspects, that is one thing. But to say conclusively  
6 that the use of cannabis by a large segment of the law  
7 profession within society is greatly affecting the manner  
8 in which laws are being performed or formulated in this  
9 country, would be a far, far different thing. This  
10 society wants to know, "Will western technological society  
11 crumble if there is an ever increasing of cannabis"? Or  
12 such a devastating question, which was debated philoso-  
13 phically not more than two weeks ago, "What chance would  
14 the Catholic church have if LSD were to be used by an  
15 ever increasing growing population"? These are not  
16 fundamental --- these go farther than the basic funda-  
17 mental questions: what does the drug do to the body?

18 PROFESSOR BERTRAND: So I think fundamentally  
19 you would (a) not provide any answers to key questions,  
20 what is the actual use which we cannot perhaps very well  
21 know, whereas the conditions of use --- and second,  
22 what would the effect be on the society of the large use,  
23 and third, what are the effects on the individual?

24 DR. SEGAL: The effects on the individual  
25 in part, but you have to emphasize here that long term  
26 chronic effects can't really be shown out on a five  
27 year moratorium, because the only way you can show long  
28 term chronic effects is to follow the mortality rate,  
29 and on second and third generations.

30 THE CHAIRMAN: I would like to pursue your



1 answer to my question a little further, Dr. Segal, and  
2 that is specifically with respect to when you suggested  
3 about getting subjects to cooperate in research, under  
4 the present legal status of cannabis use --- illegal  
5 status. Would it not be feasible to find people in  
6 various walks of life or among various occupations,  
7 who would agree to research subjects and whose use would  
8 be referred for such purpose and would prefer to be  
9 anonymous, and again would be kept confidential? I mean,  
10 I don't see what they would have to fear. They would  
11 be fully protected while they were using cannabis during  
12 the period of the research. I mean, we feel the force  
13 of the point, or one of the points you are making, and  
14 that is that research ideally ought to be carried out in  
15 condition with every day life. That is, unless we  
16 can see the effects in every day life in work and other  
17 relationships, we can't be sure we are going to get any  
18 useful research, but I don't personally see why that  
19 kind of research can't be organized with the necessary  
20 approval. What have the subjects to fear if they are  
21 willing to use the drug for that purpose?

22 DR. SEGAL: With the tone in society  
23 existing in the polarization of the controversy about  
24 the effects, and really about the good, bad type of  
25 thing that exists with a thing like marijuana, no matter  
26 how much protection you would give to a certain pro-  
27 fessional embarking on any type of research programme,  
28 I can't really see how this could remain secret for  
29 very long. Now this individual was, let us say, a  
30 medical doctor. I would be almost willing to guarantee





1 that this would affect his income. People would find out  
2 about it, this would be devastating. If he was in the  
3 law profession or if he was a teacher, this would come  
4 out, because we can't very well choose one teacher or  
5 one medical doctor or one lawyer. We still want large  
6 groups within a segment of society to determine what  
7 the effects might be on the function of those individuals  
8 within the segment of the society. And this goes way  
9 beyond the actual effects of the drugs on the body.

10 DR. LEHMANN: Well you can take ten  
11 teachers, and ten physicians and even if there was a  
12 moratorium, the polarization would still continue in  
13 society and people would soon know which of the doctors  
14 used marijuana, and then might not go to him any more  
15 if they had these preconceived ideas about it. I still  
16 don't see why it could not be organized or how it ought  
17 to be organized under the existing conditions.

18 DR. SEGAL: As far as research is  
19 concerned, this would be debatable over a long period  
20 of time. But the one thing I think did not come out in  
21 the brief here, which I have not read out, is that still  
22 under the effect of the existing cause that nothing is  
23 being done as far as those individuals in society who  
24 are using cannabis illegally, and are being convicted  
25 criminals. You can still have a law which allows the  
26 R.C.M.P. to raid a junior high school and take into  
27 custody children of the ages of thirteen, fourteen,  
28 fifteen, because there are, let us say, sugar cubes with  
29 LSD in it. And if you have a society in which a Justice  
30 Minister can get up and publicly state that, in general,



1 charges or cases coming before the courts with mere  
2 possession of marijuana will be handled in a less severe  
3 manner, then, about two or three days later you read  
4 in the newspaper about a two year sentence for possession  
5 the Government has probably three ways in which it  
6 could go: it could either leave the laws alone, as they  
7 are; become more liberal; or become more strict. The  
8 thing that bothers me is that when one gets involved in  
9 debates along the following lines to say that if we are  
10 going to change the laws, let us remove the penalty of  
11 a prison sentence, then we will leave a fine, but let us  
12 be very, very careful --- I am just making speculation ---  
13 but let us be very careful that when we catch somebody  
14 on possession or trafficking of marijuana, that we do  
15 nothing to interfere with his career, that we do nothing  
16 to interfere with his getting an education, that we do  
17 nothing to interfere with his continuing on in the law  
18 profession or medical profession or teaching profession.  
19 Then this appears to me as a paradox, because here you  
20 are playing the rich against the poor. The rich person  
21 will pay the fine. You will say that you are going to  
22 fine a company \$5,000.00 for pollution of water. If it  
23 is feasible for the company to pollute the water, then  
24 he will pay the \$5,000.00 fine. But the individual  
25 cannot pay the fine. He is unable to.

26 THE CHAIRMAN: Well you would not suggest  
27 that there be no law against polluting the water?

28 DR. SEGAL: Well no, I am not saying  
29 that, but let us be more realistic. If the Government  
30 wants to do something, or the Commission wants to





1 recommend something, then you either do one of these  
2 three things, and say leave the laws alone, make them  
3 more liberal or strict. If they are more strict, you  
4 see what happens in society, and so society turns against  
5 the law. If you make them more liberal, you find out  
6 exactly what the society does in the fact of the liberal  
7 laws, and if you leave them alone you see what society  
8 does in the fact of them. My only great concern is that  
9 I really hope that whatever the Commission does, first  
10 that the Government will listen to its recommendations.

11 THE CHAIRMAN: What do you think would  
12 be, Dr. Segal, the effect on cannabis use, of removing  
13 --- the complete removal of prohibition against  
14 possession or for that matter, generally  
15 speaking, what is your own feeling, would it increase  
16 significantly?

17 DR. SEGAL: The only thing in my mind  
18 that it would probably do is in terms of if the law  
19 remains unchanged, you will still see an increase in the  
20 use of cannabis among all age segments, and probably ---

21 THE CHAIRMAN: You did not answer my  
22 question.

23 DR. SEGAL: No, no ---

24 THE CHAIRMAN: Go ahead.

25 DR. SEGAL: If the laws are not changed,  
26 what you will see is an increased use along moderate and  
27 heavy lines over a certain period of time. What will  
28 probably happen if you alter the laws is that the time  
29 period will be much, much shorter.

30 THE CHAIRMAN: And when you alter the



1 | laws, in which way ---

2 |           DR. SEGAL: Make them more liberal. You  
3 | will have increased used along with moderate and heavy  
4 | lines taking place much quicker than if you were to leave  
5 | the laws in the state that they are now.

6 |           THE CHAIRMAN: I want to define exactly  
7 | what you mean by increased use on moderate and heavy  
8 | lines. Do you mean more users using it more extensively  
9 | or with greater regularity?

10 |           DR. SEGAL: I think you will have almost  
11 | every conceivable intermixture you can think of.

12 |           THE CHAIRMAN: Would there be a significant  
13 | increase in the number of people to start with?

14 |           DR. SEGAL: There probably would be.

15 |           DR. LEHMANN: Just experimenting, or also  
16 | in those who would use it, let us say ---

17 |           DR. SEGAL: In the first place, someone  
18 | who is using alcohol is experimenting. The person who  
19 | goes on to use alcohol more than once a week is using  
20 | it moderately, and the person who goes on any other way,  
21 | it is the same thing. The question that would be  
22 | interesting to discover would be, would there be a  
23 | summation of people who would use or, let us say,  
24 | become chronic cannabis users to the point of numbers  
25 | being chronic alcohol users, would this be summated, or  
26 | would this decrease the number of chronic alcohol users  
27 | or would there be a different population, or what would  
28 | happen along these lines?

29 |           THE CHAIRMAN, Excuse me, Dr. Lehmann?

30 |           DR. LEHMANN: You consider the possibility





1 then that there may be a summation added to the number  
2 of 3% or 4% alcoholics, there might also be a certain  
3 percentage of excessive cannabis users, some of them  
4 overlapping with the alcohol users, some of them added  
5 to it. This is a possibility.

6 DR. SEGAL: That is a possibility.

7 THE CHAIRMAN: From your own observations,  
8 your own hunch, what would you say is now regarded as  
9 moderate cannabis use in North America by users, and  
10 what is regarded as excessive or heavy cannabis use in  
11 terms of, let us say, cigarettes or --- I guess that is  
12 the main measurement --- well smoking of pot.

13 DR. SEGAL: Well, I honestly do not think  
14 that you have the standard of moderate or excessive use  
15 across the population. But I think what you do have is  
16 individual definitions of moderate or excessive use at  
17 the different levels. You have the definition-if you  
18 would go into the junior high schools-you have a  
19 different definition in the high schools, and different  
20 in the universities. And right now, there are some  
21 very interesting statistics coming out in that approxi-  
22 mately 40%, give or take a few percent, of those  
23 individuals in graduate faculties, medicine, law,  
24 graduates of school, right across the country, are either  
25 familiar with the use, have used it once or have used  
26 it more than once. But you see all of these statistics  
27 have flaws, because when a statistical survey is done,  
28 first of all it is a static survey, and what is really  
29 necessary are dynamic surveys, but dynamic surveys are  
30 expensive. Dynamic surveys will show over periods of



1 time or whether there is regional differentiations over  
2 the country. What might happen over the next few  
3 months is, a questionnaire was circulated to the fourth  
4 year medical class to the University of Toronto, by  
5 Dr. Solursh, and indicated that the University of  
6 California might be going to all the medical classes  
7 right across Canada to see what happens on a cross-  
8 country analysis, to see if there is regional differen-  
9 tiation.

10 It is an attitudinal questionnaire. Use  
11 is also in there.

12 THE CHAIRMAN: Well now, you said that  
13 moderate use, your definition of moderate use at different  
14 levels from high school to college, and accepting that  
15 in the sense of what is being regarded, what limits of  
16 moderate use have been more or less accepted?

17 DR. SEGAL: Well, at the university level  
18 it is one or two cigarettes once to three times a week.

19 THE CHAIRMAN: Once to three times a  
20 week. And that is in most high schools?

21 DR. SEGAL: I don't know, but I think  
22 that other people this afternoon will have a better  
23 estimate of that than I would.

24 THE CHAIRMAN: And what would be  
25 regarded as heavy use at the college level?

26 DR. SEGAL: I would not want to be  
27 committed to saying something like that, because I  
28 honestly don't know. I don't think they take that into  
29 consideration.

30 THE CHAIRMAN: Do you know of any use at





1 the college level by significant numbers that you would  
2 characterize as heavy, and if so, what is the extent?

3 DR. SEGAL: Without any background  
4 knowledge, I would hesitate to answer that.

5 THE CHAIRMAN: All right. You mentioned  
6 two organizations that will be here this afternoon.

7 DR. SEGAL: Well one is the Merry-Go-  
8 Round and I think we have Mr. Brian Phillips of the  
9 Halifax Youth Communication Society.

10 THE CHAIRMAN: Thank you. Are there  
11 any other observations, questions or comments before I  
12 call upon the next submission?

13 If not, thank you very much, Dr. Segal,  
14 for that opportunity of hearing you.

15 We call now Mr. Mike Hinsch of Merry-  
16 Go-Round.

17 MR. HINSCH: Well first I had better  
18 identify myself as Ron Hinsch. Mike unfortunately has  
19 pneumonia and is in the hospital.

20 THE CHAIRMAN: I am sorry. What is your  
21 name?

22 MR. HINSCH: Ron, Ron Hinsch.  
23 do  
24 What I intend to/here today is to give  
25 an outline of what Merry-Go-Round has been doing ---

26 THE CHAIRMAN: Could you speak a little  
27 closer to the mike please?

28 MR. HINSCH: Sure. What I intend to do  
29 is give an outline of what Merry-Go-Round has been doing  
30 since June 1st. The statistics that I am going to give  
you ---



1 THE CHAIRMAN: Excuse me, could you just  
2 tell us what Merry-Go-Round is?

3 MR. HINSCH: Yes. Primarily we are an  
4 organization to help people who are using drugs, who  
5 have problems with family, that type of thing. I believe  
6 we presented a brief in the last session, the last  
7 meetings.

8 What we have been doing, or the outline  
9 of techniques we have been using is to have LSD and  
10 amphetamine users-and these are the most we see of down  
11 at Merry-Go-Round. Also I would outline the problems  
12 we have had, and we have had quite a few problems,  
13 mainly because of our poor location. I also intend to  
14 outline some plans we have for the future, which at  
15 the present are still being formulated. In June we had  
16 a total number of 71 cases and this was the first month  
17 of operation. Of these, 52 were drug cases, 5 of these  
18 were people coming back for the second time. Now the  
19 10 cases were classed as medical cases, that is, infec-  
20 tions, problems with people using needles, that type of  
21 thing. Another 9 cases were social service variety,  
22 there were 3 of those.

23 THE CHAIRMAN: I didn't get that. Nine  
24 were social?

25 MR. HINSCH: Nine were social service  
26 cases, 3 of which were repeat cases.

27 THE CHAIRMAN: Repeat?

28 MR. HINSCH: Repeat. That is, they  
29 came back the second time for our counselling. Now,  
30 July, total number of 56 cases, 36 of these being drug





1 cases, 6 of them repeats, 8 medical cases; 3 of those  
2 repeats; 12 social service, 2 of which were repeats.  
3 In August, total number 57 cases, 42 cases were drug  
4 cases; 7 of those were repeats, 12 mental cases, 11 of  
5 those were repeats; 6 social service cases, 3 of which  
6 were repeats. Now, that makes up a total of 108 ---

7 THE CHAIRMAN: Could I just get those  
8 totals again now? Total cases over two months, July and  
9 August ---

10 MR. HINSCH: June, July and August.

11 THE CHAIRMAN: June, July and August.

12 MR. HINSCH: Total cases 184. Total  
13 drug cases, 130. Repeats on drug cases, 18 total;  
14 medical cases, 30 total.

15 THE CHAIRMAN: Medical?

16 MR. HINSCH: Medical, 30 cases total,  
17 repeats 16 total. Social service, 27 for a total of  
18 8 repeats. Now it is sort of broken down here. LSD  
19 accounted for 62% of the cases.

20 THE CHAIRMAN: 62% of the drug cases?

21 MR. HINSCH: Of the drug cases. Ampheta-  
22 mines accounted for 20%; opiates, 4.6%; solvents, 4.6%;  
23 barbiturates, 3.8%; miscellaneous, alcohol, mescaline,  
24 and a few other miscellaneous chemicals which I don't  
25 have the total of.

26 MR. CAMPBELL: With reference to those  
27 barbiturate cases, are these oral or intravenous barbi-  
28 turate cases?

29 MR. HINSCH: A mixture of both. The main  
30 would be oral. Mostly they are people coming in, and they



1 were using these drugs and they wanted to stop using them,  
2 and we had to give them a hand there. Others were coming  
3 in from merely taking an overdose, and I don't have the  
4 breakdown of which is which here.

5 MR. CAMPBELL: There was some intravenous  
6 barbiturate use?

7 MR. HINSCH: Yes, there was.

8 MR. CAMPBELL: Do you have any impression  
9 of the type of person? Were these former amphetamine  
10 users or former opiate users?

11 MR. HINSCH: Actually, from the amount I  
12 have seen, were people I have seen personally, were not  
13 amphetamine or opiate users at all. They were more or  
14 less confined to using the barbiturates. They had used  
15 other drugs, but their main drug habit was barbiturates.

16 THE CHAIRMAN: What is that population  
17 in terms of age and occupation that are intravenous  
18 barbiturate users?

19 MR. HINSCH: I don't know the exact  
20 figures, but the people coming into our office, average  
21 around nineteen.

22 THE CHAIRMAN: Average around nineteen,  
23 and what is their situation, their occupation?

24 MR. HINSCH: Most of them are students.  
25 I would say 90% would be students.

26 THE CHAIRMAN: 90% students. What students?  
27 Would they be in first year ---

28 MR. HINSCH: High school students, and  
29 some university.

30 MR. CAMPBELL: Have you any feeling





1 where their barbiturate use began? Was this an  
2 expression of the problem from a prescription use of  
3 barbiturates, or was it self prescribing, or non-medical  
4 from the outset?

5 MR. HINSCH: I would say most were non-  
6 medical from the outset, although there were a few who  
7 had been prescribed barbiturates by a physician, and  
8 were using them improperly.

9 MR. CAMPBELL: When they began using  
10 them, was the barbiturate use at that stage for ordinary  
11 purposes, that is to say, the relieving of anxiety ---

12 MR. HINSCH: Yes.

13 THE CHAIRMAN: I calculate there are  
14 roughly half a dozen of these on the basis of your  
15 figures.

16 MR. HINSCH: Five exactly.

17 THE CHAIRMAN: Five, yes. How would this  
18 begin? Is there any sense how they would start this?  
19 It is your impression this is their only use or more or  
20 less exclusive?

21 MR. HINSCH: It is their main use.

22 THE CHAIRMAN: Main use. Have you any  
23 sense where it came from?

24 MR. HINSCH: I really couldn't say  
25 offhand, and especially at Merry-Go-Round. I specialize  
26 in LSD cases, and the barbiturate cases, I haven't been  
27 handling at all.

28 THE CHAIRMAN: You are sure that 2 have  
29 been using intravenous amphetamine?

30 MR. HINSCH: The ones that we saw --- we



1 only say a few of these people who were using it  
2 intravenously.

3 THE CHAIRMAN: Only 2 were using barbi-  
4 turates intravenously?

5 MR. HINSCH: Yes. I am not sure of the  
6 figure. If they hadn't been using amphetamines --- it  
7 is too difficult to tell the difference between  
8 amphetamines and barbiturates.

9 THE CHAIRMAN: What did they come to  
10 you for, the barbiturates users, oral and intravenously?

11 MR. HINSCH: The two that came in for  
12 intravenous barbiturate injections, had a number of  
13 infections in their arm and they wanted it cleared up,  
14 and they wanted us to help them stop using the barbitu-  
15 rates. The others, I believe, were overdoses, they had  
16 taken. It wasn't clear to us why they had taken them.

17 THE CHAIRMAN: You said they wanted to  
18 be able to give it up.

19 MR. HINSCH: Yes.

20 THE CHAIRMAN: What did you attempt to  
21 do to help them?

22 MR. HINSCH: What we try to do, we get  
23 someone down there who wants to stop using drugs and we  
24 try to get them interested in something else besides  
25 drug use. Like they say they want to get back to school  
26 which most of them do. This was coming up to the summer.  
27 And most of these people weren't sure whether they  
28 wanted to go back to school this year or not. So what  
29 we tried to do was try to get them interested in going  
30 to school, going back to school so that they could





1 function hopefully normally in a rather chaotic situation,  
2 going to school.

3 THE CHAIRMAN: What do you mean, chaotic  
4 situation?

5 MR. HINSCH: Schools in my own opinion  
6 have never really approached the whole problem of drugs  
7 realistically. They have had a number of preliminary  
8 things, but what they have really done is presented a  
9 picture of drug use being "bad" and they have never  
10 tried to present neutral impressions of drug use.

11 MR. CAMPBELL: Getting back to the  
12 intravenous barbiturate user. People tell you different  
13 things about the effect of intravenous amphetamines, or  
14 at least there are characteristics responsible that  
15 aren't typically found in oral use, and are valued.  
16 What about the person who deals in intravenous barbiturates?  
17 Could you tell me something about what his values are  
18 in that experience, or what would provide a continuing  
19 motivation for this?

20 MR. HINSCH: The only thing I could  
21 think of, I never used them myself, but people just  
22 seem to like the calm.

23 MR. CAMPBELL: They feel much more  
24 pensive?

25 MR. HINSCH: Yes.

26 MR. CAMPBELL: Is there any tendency  
27 with those taking barbiturates to, once that habit is  
28 established, then use amphetamines?

29 MR. HINSCH: We have not detected this  
30 use.



1 THE CHAIRMAN: Dr. Lehmann?

2 DR. LEHMANN: In using barbiturates  
3 intravenously, the medical use of it is only restricted  
4 to about two purposes: one, the introduction of  
5 anesthesia, that would of course provide a complete  
6 calm; but the other fairly common use of intravenous  
7 barbiturates is to disinhibit a person; to give them  
8 the possibility to speak up and say a lot of things  
9 that otherwise they may not want to say, or couldn't  
10 say, and who would be too inhibited to relate to other  
11 people. Now, is that possibly one of the reasons why  
12 the nineteen year old would take an intravenous barbi-  
13 turate, not like what you just said, you thought it  
14 calms them, but it could also be it gives them the  
15 opportunity to be more outgoing and talk about things  
16 which,  
17 they want to talk about, without barbiturates, they  
18 wouldn't be able to.

19 MR. HINSCH: I can see that is a  
20 possibility, but we have only had 5 cases, and barbi-  
21 turate use to me is a new thing, and I wouldn't make  
22 any generalizations on 5 cases.

23 DR. LEHMANN: It would be like people  
24 drinking in order to become disinhibited so that they  
25 can talk about what preoccupies them, their problems  
26 and conflicts to other people, and share with them,  
27 that they couldn't do when they were sober. You don't  
28 know, but you consider that possibility for the user,  
29 as a motive for the use of barbiturates?

30 MR. HINSCH: Yes.

MR. STEIN: Before you go on, could you



1 give us a bit of an idea what Merry-Go-Round consists of  
2 in the way of not only staff, but as a connecting link  
3 to services in the community. It is inferred, but I  
4 wonder if you could spell it out.

5 MR. HINSCH: Yes. The Merry-Go-Round  
6 staff, as you know, is made up predominantly of young  
7 people, most of whom have used drugs before. Now our  
8 affiliation with other agencies, we have a programme  
9 now from students from Dalhousie University and we are  
10 lecturing to them once a week on drug use. We have  
11 currently, I think, 7 students in Dalhousie operating  
12 in this programme. We are also working with public  
13 health nurses, and training them and giving them our  
14 ideas<sup>on</sup>/what they can do when someone comes to them with  
15 a drug problem.

16 MR. STEIN: You have a house or a store  
17 front?

18 MR. HINSCH: Unfortunately, we work out  
19 of an office building.

20 MR. STEIN: On street level?

21 MR. HINSCH: It is up on the third floor,  
22 which is really a bad scene. We are leaving there a  
23 week from tomorrow.

24 THE CHAIRMAN: What is your financial  
25 support?

26 MR. HINSCH: At the moment, we have one  
27 agency backing us. We have raised our money from private  
28 donations. We had a couple of dances last year that got  
29 us started, but right now we are in rather a dire  
30 financial position.





1 THE CHAIRMAN: Have you made any appeals  
2 to the Government at any level?

3 MR. HINSCH: Not as yet. We were hoping  
4 we could get along without Government support. The  
5 Government has enough to do now. We feel that the  
6 private sector of the community should be doing more to  
7 help us with our type of operation in the drug problem  
8 as a whole.

9 THE CHAIRMAN: What is your budget term?

10 MR. HINSCH: Our budget right now is  
11 about \$100.00 a month.

12 THE CHAIRMAN: And that is to cover the  
13 rent, you are budgetted, there is no other necessary  
14 expenses?

15 MR. HINSCH: The drugs that we get, we  
16 use, have actually been bought for the most part by  
17 Dr. Morton who is actually our consultant.

18 THE CHAIRMAN: How many people are there  
19 involved in this --- staff?

20 MR. HINSCH: At all levels?

21 There are fifteen workers --- it is a  
22 twenty-four hour operation, and we have approximately  
23 eight, and that is a twenty-three total.

24 THE CHAIRMAN: Do you have doctors and  
25 nurses?

26 MR. HINSCH: We have one doctor present  
27 and we will have three more joining us next week.

28 MR. CAMPBELL: If you need hospitalization,  
29 are there an adequate number of beds?

30 MR. HINSCH: At our facility?



1 MR. CAMPBELL: No, in Halifax, let us  
2 say someone shows up at Merry-Go-Round and you have to  
3 take the person to the hospital.

4 type MR. HINSCH: We have had no problems of  
5 that/to date.

6 MR. CAMPBELL: There has been no problem.  
7 What about the management, do you play any continuing  
8 role once they are at the hospital?

9 MR. HINSCH: As of right now, we do not.  
10 However, we are getting into this thing where we will  
11 be doing that.

12 MR. CAMPBELL: How many similar organiza-  
13 tions are there in Halifax?

14 MR. HINSCH: At the moment, there is one  
15 that I know of, and I am not sure if we will be getting  
16 this drug thing this winter or not, and that is the  
17 Halifax Youth Society.

18 THE CHAIRMAN: What is your impression of  
19 general hospital response to drug use? Have you any  
20 observations to make?

21 MR. HINSCH: Yes, I would say it is  
22 improving, it has improved quite a bit since six months  
23 ago. We have had a number of referrals, people who have  
24 gone to the general emergency department, they phone us,  
25 and we have gone down to take a look at the person and  
26 brought him down to our centre.

27 THE CHAIRMAN: Could you tell us a little  
28 bit about the opiate cases? There were 6 out of a total  
29 of 130 drug cases between July and August. What opiates;  
30 what was the nature of the use?





1 MR. HINSCH: Four were heroin and one  
2 was opium itself.

3 THE CHAIRMAN: One opium? I don't know  
4 whether I'm accurate; there were six?

5 MR. HINSCH: Yes, there were six.

6 THE CHAIRMAN: The percentage was 4.6,  
7 I rounded it off. What was the age, the situation?

8 MR. HINSCH: Two of them were in their  
9 twenties, one was exactly twenty, and one was nineteen.  
10 The other, I think, was --- I am not sure --- eighteen  
11 or nineteen.

12 MR. CAMPBELL: What about the history  
13 of drug use, as far as the opium user?

14 MR. HINSCH: I really don't know. In  
15 two cases, they were amphetamine users before that.

16 THE CHAIRMAN: Three out of the four?

17 MR. HINSCH: Three out of the total of  
18 six had been using amphetamines before.

19 THE CHAIRMAN: I see, three out of the  
20 total of six opiate users had used amphetamines before?  
21 Intravenously?

22 MR. HINSCH: Yes.

23 MR. CAMPBELL: Steadily?

24 Quite  
25 MR. HINSCH: /steadily. We did not see  
26 them when they were on the amphetamines.

27 THE CHAIRMAN: How many of the four  
28 heroin users have used amphetamines before, do you  
29 recall? Was it three out of those four?

30 MR. HINSCH: Two out of those four.

MR. CAMPBELL: Can you tell us anything



1 that would suggest a link between amphetamines and the  
2 heroin users?

3 MR. HINSCH: They did not seem to make  
4 any connection.

5 MR. CAMPBELL: What about the reasons of  
6 the onset of the heroin?

7 MR. HINSCH: They said that they preferred  
8 heroin to speed.

9 MR. CAMPBELL: How extensive would the  
10 heroin be?

11 MR. HINSCH: Two of them are now on the  
12 methadone treatment. The other two are now back using  
13 speed.

14 MR. CAMPBELL: So of those two that have  
15 gone back to speed, when you saw them, what was your  
16 impression? Had they developed an addiction to heroin  
17 or ---

18 MR. HINSCH: They had used it, and they  
19 changed to speed saying they preferred it to heroin,  
20 and that heroin was not all that readily available here  
21 in the city.

22 THE CHAIRMAN: Is that your impression?

23 MR. HINSCH: Yes, I would say there are  
24 no more than about 20 heroin users in the city --- I  
25 would say there are between 20 and 25.

26 THE CHAIRMAN: What is their background  
27 and what is their situation; occupation?

28 MR. HINSCH: I have no general impression  
29 of the overall use, but the ones we have seen were not  
30 employed.



1 THE CHAIRMAN Not employed. And about  
2 those four heroin users --- or six opiate users, what  
3 was their occupational status?

4 MR. HINSCH: Only, I think, one of them  
5 was employed. The others did small time dealing.

6 THE CHAIRMAN: Small time what?

7 MR. HINSCH: Small time dealing on the  
8 street.

9 THE CHAIRMAN: They were supporting  
10 themselves by pushing?

11 MR. HINSCH: Yes.

12 MR. CAMPBELL: Within the population of  
13 25 users, from eighteen and up to twenty-five, does  
14 this seem to be a largely homogeneous population in terms  
15 of introduction to heroin use?

16 MR. HINSCH: This is one group I am  
17 really not too familiar with.

18 THE CHAIRMAN: Why did they come to you,  
19 the six? What did they say about their problems?

20 MR. HINSCH: Most of them were claiming  
21 to have psychiatric problems. I do not have the exact  
22 nature of their problems, and we suggested that these  
23 people see Dr. Morton.

24 DR. LEHMANN: Did they wish to see a  
25 psychiatrist?

26 MR. HINSCH: No.

27 MR. STEIN: Did they say why they  
28 needed help?

29 MR. HINSCH: When someone comes and asks  
30 us for help, we do not ask them why they want help, we





1 just give it to them.

2 MR. STEIN: You said that two had gone  
3 on methadone now, and two on speed. Are you still in  
4 touch with the ones that have gone on to speed?

5 MR. HINSCH: No, they are no longer in  
6 contact with us.

7 DR. LEHMANN: Who treats those who are  
8 on methadone now?

9 MR. HINSCH: They are being treated by  
10 a doctor outside of the Merry-Go-Round setting.

11 DR. LEHMANN: By a doctor or a hospital?

12 MR. HINSCH: By a doctor.

13 MR. CAMPBELL: In the population of  
14 amphetamine users --- 20% who have been on amphetamines,  
15 what proportion of that ---

16 MR. HINSCH: I would say about all.

17 MR. CAMPBELL: And what sort of problems?

18 MR. HINSCH: Most are really depressed  
19 people, and they keep using speed, but the pressure  
20 seems to be worse and worse all the time, so that when  
21 they finally go to us, they want us to sort of break  
22 the cycle for them.

23 THE CHAIRMAN: To what extent do they  
24 actually come with actual medical problems and <sup>to</sup> what  
25 extent is the actual coping of depression?

26 MR. HINSCH: Physical problems? I would  
27 say 10%, 15% and the remainder is psychiatric problems.

28 THE CHAIRMAN: What is the nature of the  
29 physical problems?

30 MR. HINSCH: Mostly varicose veins or



1 bruised veins, or veins that have been ruptured.

2 DR. LEHMANN: Do you see any cases of  
3 hepatitis?

4 MR. HINSCH: No.

5 DR. LEHMANN: They go to the hospital?

6 MR. HINSCH: We have no facilities at  
7 Merry-Go-Round to treat them.

8 DR. LEHMANN: But do you diagnose them?

9 MR. HINSCH: Actually, we take the blood  
10 tests, for blood tests we have to refer them to the  
11 hospital.

12 DR. LEHMANN: May I just ask about what  
13 you have just said, that most of them who take speed  
14 are depressed. Could you venture an estimate as to  
15 what kind of depression. Do you think that they might  
16 be people who have, perhaps, psychiatric problems of their  
17 own anyway individually, or that they suffer from what  
18 has been called by some a futility syndrome, that is, a  
19 social economic class, where they are feeling suppressed,  
20 powerless and helpless, and quite hopeless, and "what is  
21 this all about, I won't get anywhere anyway, and every-  
22 thing is futile", and then they become depressed and turn  
23 to speed. Now that is different from the one who might  
24 be depressed because of how his mother and father treated  
25 him at home when he was a baby, or because he had an  
26 unhappy love affair or something. In other words, how  
27 many of those speed takers who are depressed, in your  
28 opinion, are depressed because of social conditions, or  
29 the futility syndrome in society, or how many have their  
30 own individual pressure and are thus depressed?





1 MR. HINSCH: I could only give a rough  
2 estimate. I would say about 70% who feel that there is  
3 no point in doing anything.

4 DR. LEHMANN: Because of the society's  
5 problems?

6 MR. HINSCH: Right. And would remain  
7 more depressed.

8 THE CHAIRMAN: What is the status, Mr.  
9 Hinsch, of the amphetamine user, their age, and status?

10 MR. HINSCH: From what we have seen?

11 THE CHAIRMAN: Yes.

12 MR. HINSCH: Right. The average age, we  
13 are getting younger people down to us. We are not  
14 getting all the users in this city. Younger ones average,  
15 again, about nineteen, twenty. The amphetamines users,  
16 some of them will be working, will have a job while they  
17 are using speed. Most of them, their educational  
18 background is not that high. I would say that the ones  
19 we have seen have dropped out of school before graduating  
20 from high school.

21 THE CHAIRMAN: Most of them have dropped  
22 out?

23 MR. HINSCH: Right. The ones that we  
24 have had success with, taking them off of speed, we have  
25 been able to put them back into school and they have  
26 built a foundation from there, so that they can function  
27 normally again.

28 THE CHAIRMAN: What is the relationship  
29 between the two things, that you have had success in getting  
30 them back to school, or has getting them back to school



1 | been part of the success; positive success?

2 | MR. HINSCH: Right. Now others, we have  
3 | had to find jobs for. They do not have a job themselves  
4 | and they go on to find a job for other people.

5 | THE CHAIRMAN: Why do they leave school?

6 | MR. HINSCH: Most of them could not hack  
7 | it.

8 | THE CHAIRMAN: What do you mean by that?

9 | MR. HINSCH: They could not get along  
10 | with the teachers, they did not want to do the work, they  
11 | thought the school system was not really fulfilling their  
12 | needs.

13 | THE CHAIRMAN: Do you think that they were  
14 | capable of making the requirements of the system, of  
15 | meeting the test of the system?

16 | MR. HINSCH: The ones who are back in  
17 | school this year are doing very well in school. In fact  
18 | they were doing well before they dropped out, but they  
19 | just thought that the school system did not help them  
20 | in the long run.

21 | THE CHAIRMAN: Well, how did you get  
22 | them back?

23 | MR. HINSCH: I was talking with one, one  
24 | person I talked to for four hours, and just tried to  
25 | convince him --- he wanted to kick the habit, the use of  
26 | speed, that he would have to find some other things to  
27 | do to fill up that time he was using to take the speed.  
28 | And school hours help along these lines.

29 | THE CHAIRMAN: Do I understand then that  
30 | many or most of them expressed the desire to get off speed?



1 MR. HINSCH: Right. But once again, we do  
2 not usually see amphetamine users in our setting unless  
3 they want to get off.

4 THE CHAIRMAN: Well, you might see them  
5 medically, the ones who require urgent medical attention.

6 MR. HINSCH: Right. We have cheated on  
7 our statistics and put them on the medical category.

8 THE CHAIRMAN: How many cases do you  
9 feel you could claim as having got off speed, that are  
10 now cured, that are now off speed; how many cases?

11 MR. HINSCH: I am not sure of our per-  
12 centage, about six.

13 THE CHAIRMAN: They are back at school  
14 and off speed?

15 MR. HINSCH: Back at school or working.

16 THE CHAIRMAN: And they have not moved  
17 to something else?

18 MR. HINSCH: No. In fact, they have  
19 stopped using drugs altogether.

20 THE CHAIRMAN: And how many have made  
21 the attempt to get off?

22 MR. HINSCH: A serious attempt to get  
23 off, about 10 of them.

24 THE CHAIRMAN: Ten of them have made a  
25 serious attempt without relapse? Does that include those  
26 that have dropped out of school?

27 MR. HINSCH: Those are the ones who,  
28 early in the summer, were able to find part time  
29 jobs, but dropped those jobs because they couldn't hold  
30 a job because of speed, at the same time.





1 MR. CAMPBELL: I wonder if there are  
2 any alternative institutions as opposed to the school  
3 in Halifax, simply for people who are not able to tolerate  
4 high school or university?

5 MR. HINSCH: There is a new school that  
6 opened up here and I forget the exact name of it, free  
7 school, and it is a much freer school than the normal  
8 school is. It is primarily for people --- I think the  
9 oldest one the school has is sixteen and the others  
10 there are eleven up to fifteen. There are only about  
11 fifteen or twenty in that school.

12 MR. CAMPBELL: You are speaking of a  
13 school primarily for people, and I think you said the  
14 school was primarily for people. What do you mean by  
15 that?

16 MR. HINSCH: These people are young  
17 people that go to this school that has volunteer  
18 teachers and they are structured for taking marks ---  
19 if you want to go on to university, you wouldn't have  
20 marks and I am not completely familiar. They just go  
21 there to learn what they want to learn, as opposed to  
22 the regular school.

23 THE CHAIRMAN: Mr. Hinsch, I think we  
24 would like to question you further and discuss this  
25 with you further, but there is a submission scheduled  
26 from Dr. Dunsworth, who has to leave at 11:30. I wondered  
27 if it is acceptable to you if we adjourn the discussion  
28 of your submission to permit Dr. Dunsworth to speak, and  
29 then if we could resume our discussion with you?

30 MR. HINSCH: I would have to leave myself



1 by 1:00 o'clock.

2 THE CHAIRMAN: Oh yes. We will do it  
3 before we adjourn.

4 MR. HINSCH: I have an exam this after-  
5 noon.

6 THE CHAIRMAN: We would do it before  
7 that.

8 Thank you very much. I call now on  
9 Dr. Dunsworth.

10 DR. DUNSWORTH: Thank you very much,  
11 Mr. Chairman. It is difficult for me to stay as long  
12 as I would like to at this hearing.

13 My background and my reason for requesting  
14 your indulgence in hearing my submission is as follows:-

15 I am a native Haligonian, educated in Halifax City  
16 schools; as a medical doctor I graduated in 1943 from  
17 Dalhousie; I was approximately for a year, a duty  
18 medical officer in the Royal Canadian Medical Corps.

19 I was practicing for psychiatric training, first at the  
20 Nova Scotia Hospital in Halifax and for one year in  
21 training in Toronto.

22 For two years I was psychiatrist at the  
23 Department of Veteran Affairs hospital here in Halifax  
24 and then completed by training at the Menninger School  
25 of Psychiatry at Topeka, Kansas.

26 Following passing the examinations for  
27 the specialty of psychiatry, I returned to Dalhousie  
28 Medical School twenty-two years ago, first as an assis-  
29 tant professor of psychiatry and later as an associate.  
30 For seventeen years I was director of the Child Guidance





1 Clinic and for the last ten years I have been the head  
2 of the Department of Psychiatry of the Halifax Infirmary.  
3 I have been consultant to St. Euphrasias School which  
4 is a training school for emotionally disturbed and  
5 delinquent girls, and for the Family Service Bureau, a  
6 social agency dealing with family breakdown, for over  
7 15 years. I have been in the private practice of  
8 psychiatry for over 22 years. I therefore feel I am  
9 very well acquainted with community attitudes, personal,  
10 and family problems and especially the anguish felt  
11 by so many parents.

12 Professionally, I am past president of  
13 the Canadian Psychiatric Association and the Medical  
14 Society of Nova Scotia, and at present am the Nova  
15 Scotia representative on the Board of Directors of the  
16 Canadian Medical Association.

17 However, my presentation here, sir,  
18 has become an obvious responsibility to me as a child  
19 psychiatrist and especially the father of ten children  
20 and a grandfather. And it is on this basis I make this  
21 submission.

22 The reason for my submission is that in  
23 my opinion your recommendations in and the general tenure  
24 of your interim report re cannabis indicate a permissive-  
25 ness which I submit will be exploited into permissive-  
26 ness including other and even more dangerous drugs. I  
27 will focus my remarks on this drug, cannabis, marijuana.  
28 I submit that the use of cannabis produces a partial  
29 psychosis, emotionally sick associations, anti-social  
30 attitudes, a "drop-out" syndrome, possible transition,



1 to harder drugs. I do not know of possible long term  
2 effects. The evidence still is very much in conflict.

3 In relation to my first point, that  
4 the use of cannabis can produce a partial psychosis,  
5 I quote from the President of Psychiatry at the University  
6 of Alberta, Dr. Keith Yonge, in his Presidential Address  
7 to the Psychiatric Association in Winnipeg in June of  
8 this year:-

9 "In the current public uncertainty  
10 about the effects of the drugs, the  
11 significance of the primary effects -  
12 perceptual, emotional, cognitive and  
13 motivational changes which are likely  
14 to occur each time the drug is used,  
15 are overlooked. At least, they are  
16 damned by a faint mention. Yet these  
17 changes, however pleasant they may be,  
18 however transitory they may be, are,  
19 by our standards medical criteria, of  
20 the same order, though not necessarily  
21 of the same magnitude, as a psychotic  
22 disorder." --Again, quoting Dr. Yonge:  
23 "Some of our basic criteria for judging  
24 psychotic disorder are, accuracy of  
25 perception, appropriateness of affect,  
26 relevance to reality of reasoning.  
27 And in this regard there is a highly  
28 significant difference between the  
29 psychedelic drugs, including marijuana,  
30 and alcohol intoxication. The distinction which seems to have been overlooked in making the common crude comparison between the two. The prevailing property of the psychedelic drugs is of inducing illusions. Although some sheer distortion of sensory perception commonly occurs, the peculiarly insidious effects are in the exaggeration of sensory acuity. This gives rise to an illusory sense, a deepened appreciation of objects, of sounds, colours, sensations of any kind, a deeper understanding of their meaning, and a feeling of creativeness, but they are all essentially sterile, because neither social conduct nor creativeness usually are actually enhanced at all. The illusions pass with the clearing of the neurochemical disturbance, but there is likely to persist with the affected person the quasi-delusional conviction of having achieved special insight, an advanced, superior, even transcendental



understanding and appreciation of life. This leaves him with the impression of being in an exalted position of intellectual or aesthetic superiority. Unlike the fantasies of normal dreaming which provide needful mental recreation without being subsequently confused with actual experience, the drug induced illusions do tend to be confused with real experiences, an extended and expanded experience. And this tends in turn to alter the person's basic perspective of life in reality --- his concept of himself and his relationship to others and his total environment. The illusion of having achieved this special insight blinds him to realistic insight. He tends to lose his perspective of reality". -- Dr. Yonge referred to

Alan Watts.

"Like the mirage which raises false hopes of achievement, the psychedelic experience is a phenomenon of self-deception. The very name psychedelic, purporting to expand the mind is a deceptive misnomer. Illusionogenic is a truer name. These drugs essentially excite the sensory perception mechanism inducing usually illusions of magnificence and self aggrandisement. Psyche-excitant they are and psyche-deceptive. What is really being implied is that question about consequences is the assertion that a little psychotiform disorder from time to time is alright".

Quoting, again, Alan Watts:

"'No one is more dangerously insane than one who is sane all the time.' Are we as psychiatrists to subscribe to such gobbledygook by remaining silent as if it were an inconsequential matter?"  
from

My second quotation is/probably one of the most respected and quoted textbooks in pharmacology.

MR. STEIN: Excuse me, Doctor, was that last sentence part of Watt's quote or is that your observation on Watt's quote?

DR. DUNSWORTH: That was the quote of Dr. Yonge. The other quote was Alan Watts. Gobbledygook. L.S. Goodman and Gillman, Pharmacology, 3rd





1 edition, 1965. I carry it with me more for self defence  
2 and it is on Page 300 if you wish it for reference. And  
3 in this section referring to pharmacological actions  
4 in man of cannabis, these are some of the statements:-

5 "A dreamy state of altered consciousness.  
6 A disturbed perception in time and space.  
7 with higher doses hallucinations  
8 Often marked alteration in mood.  
9 Moody reverie - depression  
10 With larger doses panic states and fear  
11 of death, distorted body image  
12 Illusions are not uncommon, feeling of  
13 being a dual personality  
14 Impulsive behaviour  
15 Picture of a toxic psychosis  
16 prolonged use subjects tend to become  
17 indolent and non-productive and neglect  
18 personal hygiene  
19 Remarkable similarity between the  
20 descriptions of the behavioural and  
21 subjective effects of large doses of  
22 cannabis --- with LSD, Mescaline and  
23 psilocybin".

24 To draw on my clinical experience, cannabis usage is a  
25 group phenomenon. Often to belong to a group, we must  
26 accept some of its expectations, even though they may  
27 be dyssocial. I submit that the patterns followed in  
28 groups that abuse drugs are the patterns exhibited in  
29 anti-social groups, so called "group delinquent" behaviour.

30 I am amazed by the naivete of youth.

They quote each other as authorities on drugs. At times  
they show a suspiciousness of those who have had many  
years of clinical experience with drug abuse who attempt  
to point out the dangers. Unfortunately there are some  
adults who reinforce the propaganda of the harmlessness  
of certain drugs. I also wish to criticize the communica-  
tion media which seem to take a special delight in  
quoting vociferous proponents of legalizing drug abuse.  
At the same time, in my opinion, the medical profession



1 has been too cautious in not stating the severe conse-  
2 quences of the psychodysleptics and mood disrupting  
3 drugs, as your definition gives. Many medical decisions  
4 must be based on clinical experience; we do it every  
5 day, we must cease hiding by temporizing in our state-  
6 ments that "we need more scientific research."

7 Drug abuse has many facets. It must be  
8 stated clearly that the mind-disrupting drugs are a  
9 threat to physical and mental and social health. Anti-  
10 social attitudes: many of these are originating from  
11 the drug culture. This is obvious. The policeman's  
12 lot is an even unhappier one when he is reviled not only  
13 by the criminal element in our society, but by a sector  
14 of our society that has most to lose by the breakdown of  
15 law and order, the educated middle class.

16 When a national magazine like MacLean's  
17 in October issue, derogatorially classifies chiefs of  
18 police across Canada and indicts the R.C.M.P. while the  
19 socio-educational drop outs are given such prominence  
20 and T.V. time, it is obvious that our social structure  
21 is under severe attack. As already quoted from Goodman  
22 and Gillman, the drop out pattern in cannabis may be  
23 associated with the drug itself, but I submit the  
24 association patterns of the groups seriously increase  
25 the syndrome.

26 My analogy is "the blind leading the blind."  
27 So much of that leads to aggressive group structure, thus  
28 the mores of those in the group, especially the older  
29 and more dominant and perhaps more anti-social and  
30 mentally unstable members tend to influence the others.





1 The phenomenon of group contagion is well known in  
2 delinquency studies. I think it is one of the main  
3 factors. There is a real danger of one drug leading to  
4 another under the influence of the group.

5 My advice to adolescents and parents of  
6 adolescents, fearful as most of us are, is, know where  
7 your young people are, know who they are with and know  
8 what they are doing.

9 My concern is that at this time there  
10 are too many blandishments to follow the permissive  
11 problems in the earlier years especially in view of the  
12 propaganda noted earlier. This is a very trying time  
13 for parents who want to do the best they can for their  
14 children.

15 In my opinion your recommendations  
16 concerning cannabis are, to say the least, ambivalent.  
17 In fact, the dissenting opinion of one of your members  
18 who wants all prohibition against cannabis removed tends  
19 to indicate that <sup>you</sup> are permissive in the use of this drug.  
20 I submit that you are letting down parents because you  
21 are not giving enough opposition to the drug liberalizers  
22 who are so high in volume and so high in frequency of /  
23 I submit there is enough clinical evidence to be concerned  
24 that a proportion of individuals who start with the use of  
25 cannabis do deteriorate into the use of more physically  
26 and mentally dangerous drugs. The statement that  
27 cannabis is not a narcotic may be scientifically correct  
28 but sociologically is very deceptive.

29 In my opinion removal of cannabis  
30 possession from under the Criminal Code and transfer to  
the controls of the Food and Drug Act will be interpreted



1 as permissiveness and will likely increase drug abuse.

2 Finally, I must express my indignation at  
3 the general tenor of Chapter 6, Section D entitled  
4 "Causes of Non-Medical Drug Use" --- this appears in  
5 your interim report. How can such a learned Commission  
6 state "We are convinced that the vast majority of  
7 drug users fall within the normal range of psychological  
8 functioning"?

9 They certainly are not functioning  
10 normally when under the influence of the psychodysleptics  
11 and the effects on long term users have already been  
12 cited. Just because they don't fit into a clear cut,  
13 know psychiatric syndrome, does not say that they do  
14 not have disturbances in psychological functioning.  
15 Why are such drugs used in the first place? Is it not  
16 a symptom? Our pattern in medicine is to find out the  
17 underlying causes and treat them but we have an excellent  
18 example in psychiatry where the symptom itself, if  
19 neglected, may prove fatal. I refer to the suicidal  
20 urges in psychotic depressions.

21 Your Section D refers to psychodysleptics  
22 as producing pleasure, as escapes from world and social  
23 problems, a symptom of alientation, ad infinitum. I  
24 submit that this section, repeating the facile statements  
25 of Timothy Leary, Watts and other "worthy" characters  
26 and the selection of the letters from private citizens  
27 quoted in Appendix B, and in fact in many sections of  
28 your report, gives me cause to question whether this  
29 Commission will have any positive effects on the drug use  
30 problem in Canada and I fear that it will embolden even



1 more of our young people to experiment.

2 THE CHAIRMAN: Thank you.

3 (Applause)

4 THE CHAIRMAN: Do you have a few moments?

5 DR. DUNSWORTH: Yes, sir.

6 MR. STEIN: Doctor, I wonder if you  
7 would care to indicate to us what your views would be  
8 at this time regarding legislative controls enacted  
9 towards the users of these drugs. In other words,  
10 what I am trying to elicit from you is your present  
11 perception of what the appropriate role of the criminal  
12 law for users of drugs such as cannabis would be,  
13 regardless of the possibility of physical harm of which  
14 we may yet learn.

15 DR. DUNSWORTH: As a physician I would  
16 prefer that I make no comments on that basis. I am  
17 concerned on other levels. I feel that, frankly, one of  
18 my statements here <sup>is</sup> that the majority of abuse is a  
19 symptom. I don't know, I have no answers as to how a  
20 law should or should not <sup>be</sup>. I am concerned that the  
21 report indicates permissiveness.

22 PROFESSOR BERTRAND: I have difficulty under-  
23 standing that, when you yourself have no clear view of  
24 what could be the appropriate legislation in relation  
25 to possession, you still see any step as permissive, and  
26 you also have views on this permissiveness. I cannot  
27 understand this contradiction.

28 DR. DUNSWORTH: I am sorry I cannot  
29 understand you.

30 THE CHAIRMAN: Yes, Dr. Lehmann?





1 DR. LEHMANN: What Professor Bertrand is  
2 saying at this moment, I wanted to ask of you too: if  
3 as you just did, you say that you, as a physician, would  
4 rather not comment on possible legislation, well, if  
5 that is so, it is difficult for Professor Bertrand to  
6 realize how you could criticize permissiveness. Let us  
7 put it this way. As a psychiatrist one would see many,  
8 many, almost innumerable manifestations of behavioural  
9 symptoms. Right now in this very room here there are  
10 probably 50 people here who manifest symptoms of  
11 disturbed malfunctions and mild psychiatric disorders,  
12 by smoking, indulging in certain mannerisms, and so on.  
13 We do not have to go into details. And psychiatrists  
14 among themselves would remark on this and interpret it,  
15 in a prognosis would say, "Well, this person would probably  
16 have a bad time and should be treated" and so on. But  
17 we don't go about as psychiatrists telling people that  
18 they ought to have treatment, because they bite their  
19 nails or something.

20 Now, by the same token, and by what you  
21 said, anyone who smokes is manifesting symptoms of oral  
22 dependence. And one who drinks, manifests symptoms of  
23 dependence, to escape or dependence possibly around  
24 conditioning, maladaptive habits or what have you. One  
25 could extend this and say that people who drive their  
26 cars too quickly have certain <sup>needs</sup> / to demonstrate power  
27 and so on and so on. Well, psychiatrically this makes  
28 sense. On the other hand, as a citizen it does not  
29 really make sense, because, what is normal? Normal is  
30 for the citizen and the legislator, <sup>what is</sup> / usually accepted as



1 normality, what the average social climate reflects, not  
2 what the ideal conditions would be. Now, psychiatrically,  
3 there is no doubt about it that smoking marijuana and  
4 taking LSD is severely pathological, but so are, to  
5 repeat it again, very many, many things that are going  
6 on constantly in society, and except to psychiatrists,  
7 would be judged to be normal. Now therefore then, to  
8 conclude that one is permissive by not swooping down on  
9 those smoking marijuana, and on the other hand leaving  
10 unsaid that it is also very permissive not to swoop  
11 down on a lot of other things, that psychiatrists do  
12 not bother to ask for legislation, is somehow inconsistent  
13 to me.

14 DR. DUNSWORTH: I am not sure Mr.  
15 Chairman if that is a statement or question.

16 THE CHAIRMAN: It is a provocation.

17 DR. LEHMANN: It is a question. Perhaps  
18 then I should formulate the question. How would you  
19 explain the fact that you do accept many behavioural  
20 manifestations which psychiatrically would have to be  
21 judged as symptoms without in any way feeling able to  
22 do anything about it, and why do you single out  
23 marijuana smoking for legislation and for restrictive  
24 legislation, and more specifically, in view of the fact  
25 that you have not mentioned that alcohol produces very  
26 inappropriate emotional responses of a more dangerous  
27 kind, immediately much more dangerous than perceptual  
28 and cognitive reveries that result from marijuana?

29 DR. DUNSWORTH: Mr. Chairman, I attempted  
30 in my first comments to indicate that I was going to





1 talk about cannabis, not alcohol, not LSD, not amphetamines,  
2 etc. It is very condensed. I am sure from your interim  
3 report, I was focusing on that, and I feel that others  
4 who have not felt the same way could stand up and  
5 comment.

6 THE CHAIRMAN: Yes, I think what we are  
7 attempting to do is to understand each other's assumptions  
8 on certain matters of fact. You referred to statements  
9 on cause that you made in your report. These purport  
10 to be findings of fact, they do not purport to be advice  
11 to anyone or counsel as to how they should behave. We  
12 therefore do not purport to be permissive or prohibitory.  
13 We purport to be an attempt to identify or at least  
14 suggest some of the causes, and of course it is emphasized  
15 that we have made an impression, and so we invite help  
16 and welcome comment on it.

17 DR. DUNSWORTH: Mr. Chairman, may I make  
18 a comment on that, please? In a letter to the editor in  
19 the Globe and Mail, "Everybody is happier if pot legal",  
20 a reader claims, but what does it quote, it quotes your  
21 report.

22 THE CHAIRMAN: I know that. But the use  
23 of the interim report by people, I do not think is how  
24 we can evaluate statements of fact in the report. We know  
25 that use, all kinds of usage can be made of anything.  
26 But I am saying you infer something called permissiveness  
27 from certain statements. Now, I think that that is a  
28 conclusion. But I am interested in pursuing with you,  
29 as a medical man, your assumption --- your objection  
30 underlying the psychological condition of users. It is



1 that statement on Page 222 of the report in which it is  
2 said that there might be some tendency to think of the  
3 motives of drug users as pathological or as reflecting  
4 a pathological condition. Now we are speaking there  
5 of cause, the causes that lead one to the use. We are  
6 not speaking of the effects of the drugs themselves.  
7 This is shown by the tendency to turn to a physician,  
8 and particularly to a psychiatrist to obtain help to  
9 understand the drug problem. There is no doubt that  
10 some drug users are ill. However, the vast majority  
11 fall in the normal range of psychological functioning,  
12 and we are speaking there of their psychological  
13 condition prior to drug use. Such psychological condi-  
14 tion as leads them to drug use. I would be interested  
15 in your response to what Dr. Lehmann was expressing, I  
16 think that our views, the reason for that statement is  
17 that it turns on what one views as normal and abnormal  
18 in the conditions of modern life. And in the light of  
19 what Dr. Lehmann described as normal and abnormal, and  
20 in general reference, we made that statement. Now we  
21 invite and are grateful for any professional comment  
22 on that statement, based on professional insight, because  
23 there is no doubt that that statement is one of the  
24 statements, or one of the hypotheses that we must test  
25 to the best of our ability. So we are interested I think  
26 in what is your assumption concerning the psychological  
27 state of the majority of users, because when we speak of  
28 the majority of users, we are speaking/as opposed, in  
29 effect, to the cannabis users, because they constitute  
30 quantitatively and statistically the majority of the



1 drug user. What is your assumption about the psychological  
2 condition of the majority of such users? We say it is  
3 not in terms of what we understand in normality and  
4 abnormality, it is not pathological. That is a statement  
5 of fact. It is not a statement of whether or not you  
6 should use cannabis. It is a statement of fact. What  
7 is your assumption?

8 DR. DUNSWORTH: If focused on  
9 just that one sentence, the danger is it could be  
10 taken out of context. Let's leave that part out, though.  
11 My fear, Mr. Chairman, is, we are in a new ball game.  
12 Psychiatry some years ago, basically World War I,  
13 used to be primarily restricted, dealing with patients  
14 primarily in mental hospitals. I'm not going rambling  
15 off the subject. But psychiatry came into a different  
16 situation where you had large numbers of men and they  
17 didn't necessarily fit in. All the forces of the Armed  
18 Forces in World War I had to bring in different criteria.  
19 In World War II we had the same thing. I think now with  
20 these new drugs we have a whole new ball game. It was  
21 only <sup>when</sup>/psychiatry became much more involved in delinquency,  
22 we started to bring <sup>in</sup>/different characteristics and I think  
23 we are in a new ball game. And I think most of us in  
24 the practice are not using the old criterion, we are  
25 trying to use new concepts, and we feel a very high  
26 proportion of users of cannabis experiment on the basis,  
27 and the higher proportion is the group influence, this  
28 is my second theme. And the unfortunate thing is that  
29 group influence can go on towards seriousness and,  
30 "I don't like the good guy -- bad guy." I think it is





1 very important. There is not all that much alienation  
2 between youth and adults, there isn't. I think there  
3 has been a tendency to exaggerate the differences  
4 rather than minimize.

5 THE CHAIRMAN: If I understand you, you  
6 do not necessarily disagree with the statement?

7 DR. DUNSWORTH: I don't disagree with  
8 the standard criteria we have at the time.

9 THE CHAIRMAN: You were concerned with  
10 the general climate of opinion as influencing experimen-  
11 tation?

12 DR. DUNSWORTH: Yes.

13 MR. CAMPBELL: In terms of the idea of  
14 permissiveness, I suppose, to put it in the terms of a  
15 dichotomy, a society that is generally permissive or  
16 generally coercive, or permissive --- I would be  
17 interested if you would go a little bit further in  
18 terms of what you mean by permissive, and the dangers  
19 that you see in a permissive as opposed to a coercive <sup>society,</sup> /  
20 if that is a proper dichotomy to make?

21 DR. DUNSWORTH: That is to say I am a  
22 good guy or bad guy?

23 MR. CAMPBELL: I'm not trying to say  
24 anything. I'm just trying to get what you mean by  
25 permissive and what is wrong with it.

26 DR. DUNSWORTH: I am more concerned with  
27 another approach altogether, and that is as it has been  
28 expressed at various places at other times, to give  
29 information and to give guidance to our youth. I don't  
30 think that anybody can be given complete permissiveness



1 None of the rest of us are. None of us can be completely  
2 coerced. I won't say none of us. We would much prefer  
3 that they didn't. I think there is a pattern on a  
4 different barometer, on a different axis altogether, and  
5 that is to try to give information, to try to give  
6 leadership, not just to turn things loose. I don't think  
7 it is fair. I think that is like turning someone loose  
8 without any tools and then they turn to each other.  
9 They are leading each other, the blind leading the blind.  
10 I feel there is somewhere in between. I agree with some  
11 of the statements made, that we have not; and I have made  
12 a comment that particularly the medical profession, we  
13 have not given the leadership we should. We seem to be  
14 a little bit behind. We are getting a little bit alive  
15 now. We can't catch up at the rate at which things are  
16 going. We have to give more. We had a fair amount of  
17 knowledge long before marijuana was a major problem,  
18 in the days of opium and its derivatives and other things.  
19 Addiction is not new to medicine.

20 MR. CAMPBELL: Just being where we are  
21 with those statements, there are other statements in  
22 our report. For instance, you reject the John Stewart  
23 Mill hypothesis, but we do say, subsequent to that one  
24 aspect of social policy, (inaudible) Is that sort of  
25 statement one which you consider to be a permissively  
26 oriented ---

27 DR. DUNSWORTH: No, what I mean by  
28 permissiveness is lack of direction.

29 MR. CAMPBELL: Lack of the information  
30 upon which the individual makes his choice?





1 DR. DUNSWORTH: Lack of direction.

2 THE CHAIRMAN: By lack of direction, do  
3 you mean moral judgment?

4 DR. DUNSWORTH: Moral judgment has to do  
5 with moral health, it is not something in the abstract,  
6 helping  
it's something like/ourselves function. These  
7 rules are not brought out because they are written, they  
8 are necessary. But I don't mean just on the basis of  
9 a moral judgment, I mean in relation to --- it's the  
10 only society we have. We have to have some sort of  
11 method of feedback.

12 THE CHAIRMAN: But we have a very  
13 difficult problem here, I think you will agree, Doctor.  
14 We have two functions, at least two broadly identified  
15 functions. One is gathering reliable information and  
16 a variety of us are involved, it's not just this  
17 Commission, it's you and others and researchers; and the  
18 other is giving this kind of sound influence or personal  
19 influence in life, direction, guidance, assistance. Now  
20 it is when these two functions become confused, possibly,  
21 or inclined, that we run into difficulty. Do you not  
22 recognize that whatever judgments are ultimately taken  
23 about the kind of direction or influence that should be  
24 given, <sup>in</sup>the various areas of life where that is open,  
25 family, schools, friendship and so on, do you not agree  
26 that that must rest for the long term of society, that  
27 must rest on the substratum of reliable information or  
28 at least it should (inaudible) on the substratum of  
29 reliable information?

30 DR. DUNSWORTH: No question about that.



1 THE CHAIRMAN: You would agree we cannot  
2 allow, whatever this directive may be, <sup>or</sup> what others feel  
3 what the responsibility may be, we can't allow this  
4 to interfere with the process of getting at the fact  
5 of establishing the substratum of reliable information?

6 DR. DUNSWORTH: Reliable information, but  
7 I quite frankly feel there has to be a degree of guidance.

8 THE CHAIRMAN: You are considering the  
9 use of information. That of course we have to give a  
10 lot of thought to, but we have been asked to ascertain  
11 certain matters to the best of our ability, and certain  
12 matters of fact and then what you do with them is your  
13 view, and that is obviously a matter --- we have taken  
14 perhaps a simplistic view of our tactics, but we have,  
15 to the best of our ability, to get to the phenomenon, and  
16 disclose of it the best we could. Our terms of reference  
17 seem to give us quite a straightforward mandate in that  
18 respect and this may be a matter of --- I don't know,  
19 I wasn't present at the discussion behind the (inaudible)  
20 Commission, but I assume some thought might have been  
21 given to an inquiry of this kind in which a Commission  
22 would be presumed to do its best to disclose as fully  
23 as it could what it has ascertained.

24 DR. DUNSWORTH: As well as recommendations?

25 THE CHAIRMAN: Yes, so that is our  
26 position. It is not to defend the Commission, it is  
27 <sup>that</sup> just we constantly live with these two functions, and the  
28 confusion which may occur between them, and the conflicts  
29 between them.

30 MR. CAMPBELL: I would like to come back



1 to this idea --- not to dispute it, but just to take it  
2 further. What in your view is the problem of guidance  
3 that should be given around the information?

4 DR. DUNSWORTH: I am concerned that many  
5 of the youth are only hearing from other youth, and they  
6 are not hearing the other side of the story.

7 MR. CAMPBELL: I wouldn't want to dispute  
8 that with you either.

9 DR. DUNSWORTH: I feel that someone who  
10 knows the other side of the story can sit down, and  
11 they can rap together.

12 MR. CAMPBELL: How would you suggest in  
13 a concrete way that this can be done? Is it a question  
14 of approving more people to spend this time, or is it  
15 a question of improving credibility?

16 DR. DUNSWORTH: I think that the  
17 source--I don't think it should ever be pinned down to  
18 any one school teacher, doctor, etc., etc. I think it  
19 is a total society responsibility, and that means  
20 information and attitude of parents, it means information  
21 and attitude of teachers, physicians, all others who  
22 might be able to give it, not on the idea you have got  
23 to listen on the basis of, "Look, here are some of the  
24 things ---". There has to be a degree that they will  
25 be able to make their own choice. There has to be.  
26 This is part of our society. But on the other hand, if  
27 they are not getting the other information, the other  
28 side, and if they are not given a degree of guidance ---  
29 I think it is very important. There are some individuals  
30 who seem to be able to relate things to others, and I





1 feel that this last witness that was here, I feel it is  
2 quite obvious in his way I think he has a sincere  
3 interest in the youth, and I think this is probably a  
4 very, very important factor.

5 MR. CAMPBELL: Now, the role of a person  
6 who is playing the guiding role, do you see his role  
7 primarily as an information disseminator or as an  
8 interpreter, or as a selector of information?

9 DR. DUNSWORTH: I think all.

10 MR. CAMPBELL: In terms of-let's take  
11 the latter, the selection of information. What sort of  
12 criteria would we install here?

13 DR. DUNSWORTH: I think that is a little  
14 too broad.

15 MR. CAMPBELL: Here in Halifax, or, we  
16 were here six months ago and at that point a great  
17 number of people have been coming before us here and  
18 in other parts of Canada, and saying, "Now look, one of  
19 the problems that has developed is that in drug education  
20 programmes, the information given is either incomplete  
21 or in some cases, it is inaccurate, readily discernible  
22 errors have been found. So make your information complete,  
23 make it honest, make it factual." We have heard that  
24 very frequently. Then we heard in Halifax, among other  
25 places, that it wasn't enough when providing information  
26 to simply say that, "Drug X has the following physiolo-  
27 gical effects". But, it has a number of substantially  
28 subjective effects. Now, amongst the subjective effects  
29 of cannabis (inaudible). This has to do with the effect  
30 of the drug that people say, it has done this "nice"



1 thing." Is this the type of information that should be  
2 provided or should this be censored out of the information  
3 provided?

4 DR. DUNSWORTH: That is a very complicated  
5 question. I should first of all like to refer to the  
6 complete information. I do not think it is fair for any  
7 of us to ever try to censor out such information; that  
8 you are cutting out very necessary information. I think  
9 that is playing dirty pool. On the other hand, I feel,  
10 and I will make a comparison in relation to my practice  
11 as a physician: he has to use a degree of selection as  
12 to how much information he gives to his patient. He  
13 will drive that poor patient up the cotton picking wall  
14 if he talks about all the possible things that could  
15 happen. Dr. Lehmann, who is a world renowned authority  
16 on drug investigation--if the patients who have been  
17 helped so much in the past fifteen or sixteen years by  
18 many, many anti-depressant and anti-psychotic drugs, had  
19 they in their relevance been told the positive side  
20 effects, they never would have had these drugs. So  
21 with your question, sir, I think there has to be a lot  
22 of judgment. I don't think you can chop out or censor  
23 out information that doesn't necessarily come to the  
24 cause. I think you have to give guidance, and I don't  
25 think just to give facts is right.

26 MR. CAMPBELL: Who is the appropriate  
27 person, who has the skill?

28 DR. DUNSWORTH: I think all of us in our  
29 own way. I don't think it is just one profession or one  
30 group.





1 MR. CAMPBELL: Then your view is not for  
2 selection of formal social policy ---

3 DR. DUNSWORTH: No, no. I think education  
4 is much broader.

5 THE CHAIRMAN: I think Doctor, we have  
6 kept you considerably beyond the time when you had to go.

7 Thank you very much.

8 DR. DUNSWORTH: Thank you very much for  
9 your hearing, sir.

10 THE CHAIRMAN: I call now on Dr. Wilkie  
11 Kushner, Adolescent Psychiatrist.

12 Dr. Kushner?

13 DR. KUSHNER: I don't really think I need  
14 go into my references here. I just want to state why  
15 I did not submit anything to the Commission last time  
16 you were here. This was because <sup>I</sup> was a correspondence  
17 representative of the Psychiatric Association Committee,  
18 and I did not quite realize what was involved in this,  
19 and I ended up submitting a brief to the committee  
20 preparing the brief, and much of what I have to say was  
21 not incorporated in the brief of the C.P.A.

22 MR. CAMPBELL: We are having trouble  
23 hearing you.

24 DR. KUSHNER: I am sorry. I ended up  
25 submitting a brief to the committee preparing the brief  
26 and much of what I wish to say was not incorporated.  
27 But it does not really seem to matter, because of the  
28 the balanced dispassionate report you put out. I must say  
29 I am most impressed with it. I did have some qualifica-  
30 tions to make. I did not really expect to have to talk



1 about cannabis today, because of your approach to  
2 cannabis, and what you have said about it. But I feel  
3 that Dr. Dunsworth's statements do require some qualifi-  
4 cation. I think, basically, when talking about  
5 cannabis, particularly from a professional point of view,  
6 one has to recognize where the person is talking from.  
7 Dr. Dunsworth's ideas --- I am sure he felt that  
8 within his frame of reference, were quite accurate.  
9 But the question is, who does he see that has used  
10 cannabis, and what sort of effects have these people  
11 experienced with cannabis. As a psychiatrist he is  
12 obviously talking very much about mental health and  
13 mental illness, and this is fair enough. And if the  
14 effect of the drug can perhaps be interpreted as a form  
15 of mental illness, then as a psychiatrist I dare say he  
16 is quite correct to talk about it in this way. But the  
17 fact is that he did say that it was a partial psychosis  
18 which is not too bad, and he did imply that so far as  
19 we know, the effects of this are temporary and the  
20 person does come back to normal. So if he only sees  
21 those who are very badly damaged by the drug, and again,  
22 I suspect that many of the people he sees in his consul-  
23 tant capacity at St. Euphrasia School are not solely  
24 cannabis users, but they show drug promiscuity, and use  
25 considerable amounts of drugs, and therefore these  
26 people are possibly considerably more damaged, probably  
27 before they started, and certainly after, than those that  
28 other psychiatrists might see, or other agencies might  
29 see, or certainly that the youth see among themselves.  
30 Because in order for a person to reach professional



1 health, then he has<sup>had</sup>/to be filtered/<sup>through</sup> a wide screen and I  
2 would suspect that there is a very small percentage of  
3 persons who do. When he states that youth quote each  
4 other on drugs, I would also state that adults do the  
5 same. A lot of studies are quite bad --- just to support  
6 my point of view I remember one study that appeared in  
7 the Psychiatric Association Journal which studied about  
8 thirteen or fourteen cannabis users and found that they  
9 were all professional people. Just about pillars of  
10 society, above average intelligence, very stable people  
11 indeed. That is fair enough. <sup>But,</sup>/why did they choose these  
12 fourteen. I would suspect that it was because the  
13 person who wrote this paper was trying to prove a point  
14 of view. And I think you get this with a lot of  
15 literature on drugs, and therefore, the adults are  
16 talking among themselves and they are perhaps discarding  
17 literature which they do not agree with, and they are  
18 using other authorities to clarify their own statements.  
19 So the youth can talk to each other, and adults can  
20 talk to each other, but they all start with a particular  
21 point of view.

22 I think perhaps I will stop here. I  
23 would like to go on to amphetamines, because I think,  
24 maybe my comments about amphetamines are because I find  
25 it very difficult to be dispassionate about a drug that  
26 is so powerful, so dangerous, so prone to produce  
27 dependency. I dare say that Mr. Watt in his submission  
28 this afternoon concerning Digger House will be able to  
29 add a lot to this. We seem to be unsure about the  
30 existence of physical dependency on this drug. We have





1 no doubt about development of tolerance and the develop-  
2 ment of psychological dependency. The evidence you say  
3 is perhaps against physical dependency, the blood  
4 pressure, respiratory rate return to normal after a  
5 period, and you imply that exhaustion, excessive sleep  
6 and increased appetite is a normal recuperative process  
7 of the body to make up for what is lost during the speed  
8 run, and you imply that perhaps the mental effects are  
9 psychological. But there is some definite evidence.  
10 As you state at one point, there is some physical  
11 dependency. You quote a paper where small doses of  
12 amphetamine are given to medical students and they showed  
13 that there was a suppression of the phase of sleep. Two  
14 months after stopping this two week phase of amphetamines  
15 in small doses, there was still this effect which was  
16 demonstrable and this is a physical effect. The mental  
17 effects seem to be the same as the abstinence syndrome,  
18 the mental effects after withdrawal are quite the reverse.  
19 It is very difficult to measure, it is difficult to  
20 quantify the misery, depression, despair. There is lack  
21 of energy almost to the point of apathy, there is  
22 perhaps the feeling that the mind is dead, because it  
23 hardly seems to turn over. These are pretty powerful  
24 effects, and I would suggest that this is indeed a form  
25 of physical dependency. The reason I am stressing this,  
26 I don't think it makes so much difference in the long  
27 run, is to put forth my point of view that this drug is  
28 extremely powerful. It has tremendous potential to  
29 danger. And I think that we must really make this very  
30 clear to people. You also seem to question whether the



1 slogan "speed kills" is correct or not. I would suspect  
2 that speed does indeed kill. First of all, it is very  
3 difficult to measure what happens to speed users who  
4 have dropped out of our society, and are drifting around  
5 and seem to completely disappear. We do not know if  
6 they are in another city, we do not know where they are.  
7 They might be dead, they may be somewhere else. We do  
8 not know what is happening to them. We know about the  
9 harm that is caused by amphetamines. <sup>There is</sup> the lack of ability  
10 to cope with life, a tendency towards isolation, and  
11 prone to episodes of anger, loss of control, perhaps  
12 even paranoia. Amphetamine comes closer to paranoia  
13 than any other drug that there is. There is a tendency  
14 to physical abuse. The whole scene is fraught with  
15 violence and depression, and we see this now in  
16 Vancouver, it is like a jungle out there. In addition  
17 to the physical thing, assuming that the amphetamines  
18 increase metabolic processes, these people need more  
19 food stuffs and they do not get it possibly because  
20 their appetite is suppressed, and partially because of  
21 the lack of money, because it costs a lot to support  
22 their habit, and these people are prone to illness such  
23 as hepatitis and abscesses and all the rest of it. They  
24 are also prone to hemorrhages in the lungs because of  
25 the use of talcum powder or sugar and these things do  
26 tend to cause damage. So we have this physical/going on <sup>thing</sup>  
27 with it. Mentally we see a change in the personality  
28 and life style/to all intents and purposes this is a  
29 result.

30 <sup>most</sup>  
So I would say in/ respects, speed does





1 kill and I do hope I am being dispassionate about this,  
2 although I have seen some who have suffered through this  
3 and within the framework that I have to operate. And I  
4 would really like to warn people about the use of this  
5 drug.

6 MR. STEIN: Could I ask you a question  
7 about this? In the course of your work, people who are  
8 using speed, have you indicated that the "speed kills"  
9 concept is one of the attractive aspects of the use of this  
10 particular drug, in other words, over simplified, those  
11 who are feeling extraordinarily depressed are attracted  
12 to a drug which they may feel is going to terminate  
13 their lives?

14 DR. KUSHNER: Well, in my experience, and  
15 you have to realize the fact that I am a psychiatrist,  
16 that people come to me because they want help. To my  
17 experience, people desperately want to get off, but  
18 they can't. They can't put up with the mental and  
19 physical anguish during the withdrawal. They can't  
20 put up with people who are hooked on speed coming up to  
21 them and saying that "I have a fix for you."

22 And they go through a great deal of  
23 anguish trying to get off and knowing how difficult it  
24 is and not succeeding.

25 MR. STEIN: I appreciate that, but what  
26 I was trying to elicit from you was some indication of  
27 what you might perceive as some of the early causative  
28 factors that enter into their selection of this drug?

29 DR. KUSHNER: The ones that I have seen,  
30 and I have not seen the so-called (inaudible), some



1 did it for pleasure, some did it because the effects  
2 of speed were misrepresented to them, and they thought,  
3 "It is impossible for me to develop a tolerance, it  
4 happens to the other guy but not to me." I have not  
5 seen anyone that could be called a death risk, but this  
6 could happen in the population.

7 THE CHAIRMAN: Dr. Lehmann?

8 DR. LEHMANN: Would you consider the  
9 possibility that making a slogan out of "speed kills"  
10 because heroin kills and all kinds of things kill,  
11 overeating may kill and so on, but one does not make  
12 a slogan out of it. Would you consider the possibility  
13 that making a slogan out of it might have the reverse  
14 paradoxical effect as Mr. Stein just said, of attracting  
15 morbidly at least a small number of those who, not only  
16 have death wishes, but perhaps want to play the role  
17 of the martyr, want to play the role of those, that if  
18 nothing else important can happen to them, they can at  
19 least set a bad example and say, "Don't do what I do", as  
20 many of these speed freaks are doing. So that at least  
21 by propagating this slogan as such, it might intervene  
22 or interfere or strengthen the morbid use of the slogan.

23 DR. KUSHNER: It may very well be true.  
24 I can only hypothesize about this. I know that a lot  
25 of the so-called pleasurable things that people do,  
26 climbing mountains, jumping out of airplanes as  
27 parachutists, I saw a whole series of pictures of  
28 somebody who dropped out in a group without a parachute,  
29 a lot of people do tend to flirt with danger because  
30 perhaps they feel there is no excitement in society, and



1 they have to create their excitement, and therefore  
2 participate in very dangerous activities. It may very  
3 well be true, but I could not say from experience. It  
4 is all supposition on my part.

5 DR. LEHMANN: By the same token then,  
6 if you propagate a slogan, "parachute jumping kills",  
7 you might draw a small number of people into it who  
8 otherwise may not have done it?

9 DR. KUSHNER: Perhaps yes.

10 Can I continue? Your exposition on law  
11 and drugs is very good. I would agree with you that  
12 ideally the state does have the responsibility to restrict  
13 the availability of harmful substances. I agree with  
14 that ideally. But if this is the case, I feel we should  
15 try to be more consistent and I think it is a lot of the  
16 inconsistencies in this that are causing many of the  
17 attitudes presently existing among drug users. For  
18 example, why would you ban cyclamates when no human can  
19 ever hope to come near to taking in the quantities that  
20 are carcinogenic in animals and when obesity itself is  
21 such a tremendous cause of (inaudible) . Why is  
22 there no public questioning about the drugs of the  
23 silent majority, barbiturates and tranquillizers. Why  
24 allow the introduction and importation of quantities of  
25 barbiturates and amphetamines which everybody knows to be  
26 well in excess of that needed for legitimate use, even  
27 assuming that much of the so-called illegitimate use is  
28 indeed legitimate. Why allow advertising like this,  
29 which is sent out to all physicians, which, I think, is  
30 an obscene ad which really says, "Turn your patients on





1 with Ritalin". Why allow a thing like this, because  
2 Ritalin has the same sort of dangers as amphetamines do.  
3 Why allow tobacco? You know about the dangers of  
4 tobacco and why classify cannabis as a narcotic? We  
5 know that there was absolutely no scientific basis for  
6 this law in the first place. There is a lot of supposi-  
7 tion; a lot of muddling against this thing, of Anslinger  
8 starting the whole thing off and it just creates a lot  
9 of confusion, and there are a lot of inconsistencies  
10 about this, and you yourselves in your report get caught  
11 up in these inconsistencies.

12 I would like to read for you from Section  
13 457 of your report, where you say: "In view of the  
14 paranoia associated with the excessive use of amphetamines  
15 and methamphetamines, we do not think it would be  
16 socially helpful or desirable to attempt to apply the  
17 criminal law and the enforcement methods which seem to  
18 be necessary to the simple possession of these drugs for  
19 non-medical use. We believe/<sup>that</sup> such a course could lead to  
20 <sup>increase</sup> a substantial/in violence and other undesirable social  
21 effects. We place much more hope and confidence in  
22 education and cultural controls as a means of reducing  
23 the use of 'speed.'" Well, that is fair enough. You say  
24 these drugs <sup>cause</sup> / aggression, cause paranoia, and you say  
25 that people who are perhaps feeling they are being  
26 harassed by the police might therefore have an additional  
27 burst of anger added to this. Therefore, "let's leave  
28 them alone and let's just go against people who are  
29 using drugs and make them quiet and calm and not a  
30 danger to anybody." Now this to me doesn't make sense,



1 because amphetamine is the most dangerous and harmful  
2 of all drugs, and yet because of these dangers and because  
3 of the effects upon them, you are suggesting we just  
4 don't bother, because they might get worse when they are  
5 being harassed, or if we have laws against their abuse.  
6 Now, to my mind that doesn't make sense. Now, assuming  
7 there is consistency so that all harmful substances are  
8 restricted in a manner respondent with the potential  
9 dangers, I feel it would still be Utopian. You go on to  
10 say that restriction is a proper object of criminal law,  
11 except for amphetamines. But that is good. But how  
12 does society enforce it? I would submit these laws  
13 are really virtually unenforceable. We heard Dr.  
14 Dunsworth a bit earlier refusing to get involved in  
15 what the possible course of action should be. Well, I  
16 think that is Utopian too, and I think that is a cop-  
17 out. I don't think people can exist in the ivory towers  
18 of their consulting rooms any more. We have got to  
19 look at the total effects of the situation. In any drug  
20 that is being introduced, we have always got to weigh  
21 the odds. We have got to balance the possibility for good  
22 against the possibility for harm, and it is always a  
23 gambler's game. It is always a question of playing the  
24 odds. In the treatment, for example, of leukemia and some  
25 types of carcinoma, we give drugs that are extremely  
26 dangerous, extremely harmful and have a great deal of  
27 physical, harmful side-effects. We do it because it is  
28 the only thing we have got. We do it because the  
29 alternative is the death of the person; therefore we  
30 give them something that will make them feel awful,





1 because it is the only thing we have got. If something  
2 better comes along, then we will suppress these drugs  
3 that are being used, and we will give them the ones that  
4 are better. We use penicillin knowing that about 15% of  
5 the population are sensitive to penicillin and if they  
6 get penicillin they will die. But we still use penicillin  
7 because 85% of the population are not sensitive to it,  
8 and 85% of the population can have their lives saved  
9 by penicillin. We use all sorts of substances. We use  
10 aspirin, for example, which is a very harmful toxic drug  
11 and no one knows how toxic this drug may be. We use it,  
12 by and large, because it does have a certain effect, an  
13 effect that is wanted, an effect that is needed for  
14 arthritis, headaches and pains of all sorts. So we are  
15 always having to try to weigh the odds and balance the possibility of the  
16 good against the possible harm and that is fair enough.  
17 Now with these drugs, you get into a totally different  
18 situation. It is awfully hard to find the balance. It  
19 is awfully hard to weigh a possible good when you are  
20 dealing with something as nebulous as "pleasure". I  
21 know many of these people take these drugs for pleasure,  
22 at least at first. We know the possible harmful effects,  
23 and therefore if we can say, "Well the possible good is  
24 something that is nebulous, and the possible harm is  
25 this, that and the other thing, therefore let's suppress  
26 them", then we add a completely new dimension and then  
27 we start getting into the socially toxic effects, toxic  
28 effects that are not related to the drugs themselves,  
29 but the toxic effects due to the attitudes of society,  
30 and the attitude society takes to control these drugs,



1 therefore there is a whole new dimension of toxicity  
2 added and a whole new ball game is constructed. And  
3 this to my mind is possibly dangerous. With new drugs  
4 that are coming in, there is a whole framework the  
5 people go through, a whole framework for testing, a  
6 whole framework for submission for a licence to manufac-  
7 ture and distribute these drugs. But this framework  
8 doesn't exist, because these drugs are already here and  
9 there does not seem to be any way that we can get rid  
10 of them. Cannabis, perhaps, is easy to get rid of, or  
11 relatively easy to get rid of because it is so visible,  
12 because we know where it has got to be grown, we can  
13 watch the way it is brought into the country as much as  
14 possible. It is awfully hard to hide a dime of  
15 cannabis. But what about LSD which is made by the present  
16 day moonshiners, which is colourless, odourless and  
17 tasteless, where I can be walking around now with as  
18 much LSD to get everybody in this room high,  
19 dissolved in my tie. Who could catch me with it  
20 unless they start smelling bits of all of my clothes.  
21 We just can't control it because it is made in somebody's  
22 back room, it can be sent around the country dissolved  
23 in water, dissolved in a letter, dissolved in an article  
24 of clothing. We are giving our police an impossible task.  
25 The same with amphetamines. A large quantity doesn't  
26 take up much space. It is possible to secrete these  
27 drugs anywhere, and the police simply can't cope with  
28 this, and the only way they can cope with it, is either  
29 to multiply the police force manyfold, or give them  
30 unlimited powers, create the equivalent of the War



1 Measures Act for drugs. We just can't do that, because  
2 of the socially toxic effect that will result. Now, I  
3 don't know what to do here. I am confused about this.  
4 There are times when I say, "Let's legalize all drugs"  
5 and let's cope with education where you yourselves mention  
6 about amphetamines. If there is a balanced  
7 education programme where people can learn the effects  
8 of all drugs, that all drugs are potentially dangerous,  
9 and there is no such thing as a safe drug, and <sup>that</sup> any drug  
10 taken in the wrong way, at the wrong time, in the wrong  
11 dose at the wrong place can do harm, and then go into  
12 specifics, then maybe with an educational programme we  
13 can find some way of getting people to realize what is  
14 involved with drugs. And there are some drugs, LSD,  
15 that scare me, and amphetamines certainly scare me, and  
16 the opiates I have no experience with, personally. So  
17 maybe this will work. You say that it seems to working  
18 with amphetamines. I certainly hope you are right. But  
19 we certainly can't suppress without education because of  
20 all these horrible effects that <sup>would</sup> result because of the  
21 attempted suppression. But then again, what happens if  
22 we just take off all controls? Will they blow up? Will  
23 we get into more disasters? I really don't know. I do  
24 know that we are a chemical oriented society, that  
25 we all use drugs of some sort or another, that these are  
26 things that we as a society are going to have to cope  
27 with. Prohibition didn't work in the United States, and  
28 we all know what the effects of that were, and we are  
29 trying to recreate the same situation now. And this  
30 disturbs me because if it controls this with education,





1 given time any society can learn how to cope with it,  
2 if they learned how to cope with alcohol. Spain and  
3 Portugal, all the big countries just learned to cope  
4 with alcohol because it was part of society, it was  
5 considered acceptable and therefore people who tried to  
6 act out against society did not have to use these  
7 substances as parallels <sup>with</sup> their acting out, whether  
8 external or internal conflicts. So given time, I am  
9 sure society can learn to come to terms with it. I  
10 don't know whether we have got time. I don't know what  
11 is going to happen if we lift controls. I know a lot  
12 of these controls and the effects of these controls upon  
13 a particular population tend to be more damaging than  
14 the effect of some of these drugs.

15 THE CHAIRMAN: Dr. Lehmann?

16 DR. LEHMANN: Dr. Kushner, as somebody  
17 who has a great deal of experience with dangerous drugs,  
18 and their use, and somebody who has thought a great  
19 deal about it, you now come to the position where you  
20 definitely do not "cop out" as you put it, you do face  
21 up to the question as you say everybody has to face up  
22 to the question of what should be done about controlling  
23 them. And then you say that some of the most dangerous  
24 drugs cannot be controlled. It is technology impossible,  
25 LSD for instance. And for the rest you say, "Well, we  
26 have seen the terrible effects of suppressive legislation",  
27 something like the War Measures Act and so on, that must  
28 be done. And then you say, "Well, I just don't know".  
29 Something ought to be done, but "I don't know". And if  
30 you don't know what ought to be done, you should know



1 because you have had a lot of experience, a lot of  
2 professional qualifications, and a great deal of very  
3 conscientious thinking about it.

4 DR. KUSHNER: Well, are these things  
5 working? (indicating microphone)

6 THE CHAIRMAN: I don't know.

7 DR. KUSHNER: Are these working?

8 THE CHAIRMAN: Would you speak into one  
9 of them closely.

10 DR. KUSHNER: I feel very, very tempted  
11 to say, "Let's lift off all controls and let's deal  
12 with education only". I should say I am involved in  
13 doing this myself. I am about three-quarters<sup>the way</sup> of a  
14 text book that hopefully will be used in the schools.  
15 I have bogged down a bit on the reasons why people take  
16 drugs because it is very difficult to conceptualize,  
17 but I put my faith in education. This is going to take  
18 a great deal of time. Equally, though, it is going to  
19 take a great deal of time to<sup>lift</sup> these controls because we  
20 have got a great deal of international conventions we  
21 have got to get out of, and we have got to stand up in  
22 front of the United States, /<sup>who,</sup> I don't think are going  
23 to stand for this anyway, and we have got to stand up  
24 for very, very deeply felt and very emotional opinions for  
25 the other way. It is certainly going to be a very unpop-  
26 ular decision if we do this. But I think on balance I  
27 would come down in favour of lifting all the controls.  
28 The reason for hesitation is that I don't know what is  
29 going to happen, and I can only fantasize; I can only  
30 hypothesize. We do know in other societies when controls





1 were lifted, gradually drugs became part of the society,  
2 and people learned how to handle them.

3 THE CHAIRMAN: That is your hypothesis?

4 DR. KUSHNER: That is my hypothesis. It  
5 can only be hypothesis. We do not know what is going to  
6 happen. We know what is happening now, better we know  
7 than we don't know. But what is happening now frightens  
8 me, and because it frightens me I wonder if there is  
9 not an alternative. But the alternative is something we  
10 cannot just do anything but hypothesize for.

11 THE CHAIRMAN: Well, on amphetamines, on  
12 which you express such concern, and to which you refer  
13 in our report, what do you feel should be done about  
14 the legal approach to the simple possession of  
15 amphetamines?

16 DR. KUSHNER: In view of my feelings about  
17 all this, the only thing that I can say is "Let's forget  
18 about it", because of the fact that the police do not  
19 seem to be concentrating on amphetamines anyway, they  
20 are going after cannabis. They do not bother with the  
21 more dangerous drugs. It is always more visible to get  
22 the cannabis user, and you get more excitement out of  
23 it. Nobody bothers too much about someone who's arrested  
24 for amphetamines.

25 THE CHAIRMAN: Any other questions?

26 MR. CAMPBELL: Suggestions have been made  
27 to us that in the case of the individual who is shooting  
28 amphetamines, that he can only go on doing this for a  
29 certain length of time and that then there will be a fairly  
30 high probability of his then switching to other drugs,



1 like the opiates. There is some evidence in the United  
2 Kingdom where they were able to control intravenous  
3 amphetamine use almost completely, but in the period  
4 following that control there was a mark up in barbiturate  
5 use and so on. Would your experience suggest <sup>that</sup> / this is  
6 a frequently occurring sequence?

7 DR. KUSHNER: I can only hypothesize on  
8 that, because I have not had experience myself with this.  
9 I know this has happened in the United Kingdom and I  
10 know there is the possibility. I suspect that part of  
11 the difficulty is that when you are intravenously  
12 injecting amphetamines, the rush is so quick, almost  
13 before he gets the needle out of the vein, that a  
14 conditioned response is sent out to the needle itself  
15 and this is something that is difficult to overcome.  
16 But this is a suspicion. Unfortunately, we do not have  
17 adequate facilities for treating amphetamine users. We  
18 have got organizations in Halifax who are trying as  
19 hard as they can to cope with the situation, but they  
20 are overwhelmed. The Digger House has been overwhelmed  
21 by it, and they have to rethink what they are doing and  
22 where they go from there. My results with amphetamines  
23 users have been very bad indeed. I am desperate. I  
24 have tried all sorts of things.

25 THE CHAIRMAN: When you speak of treatment,  
26 you do not mean just the acute effects, but long term?

27 DR. KUSHNER: Yes, indeed. I am  
28 wondering if we should not be setting up something  
29 similar to Cinenon for heroin users.

30 THE CHAIRMAN: In other words, you are



1 talking about getting people off the amphetamines?

2 DR. KUSHNER: Indeed. There are so many  
3 people who can't come off without something giving them  
4 a great deal of support, and over a long period of time.

5 THE CHAIRMAN: And these are people who  
6 have expressed a wish to get off?

7 DR. KUSHNER: Yes.

8 MR. CAMPBELL: You have expressed this  
9 very real concern for the relative dangers of the  
10 amphetamine. Do you see an equally great potential for  
11 the harm of intravenous barbiturate use?

12 DR. KUSHNER: Yes, because it is the  
13 same, it causes tolerance, and it is completely outside  
14 of my experience. I have read reports, I have seen  
15 people who are dependent on barbiturates in Scotland,  
16 but I have not seen anything here. These were middle  
17 aged people who had started on barbiturates because they  
18 were the wives of physicians themselves, and they had  
19 access to it. I have not seen anything comparable to  
20 intravenous use of barbiturates, so I can only suppose.  
21 It may very well be because of the effects of barbiturates  
22 that these people will not be such a danger to society,  
23 they will not be so aggressive and they will not be the  
24 same sort of sub-culture that has developed now with our  
25 amphetamines users, which is quite possible. But this  
26 is outside of my experience.

27 MR. CAMPBELL: How long is it since you  
28 have practiced in the United Kingdom?

29 DR. KUSHNER: I came here in the spring  
30 of 1968.





1 MR. CAMPBELL: Were you practicing there  
2 in the period when the clinics were in operation?

3 DR. KUSHNER: For opiate users?

4 MR. CAMPBELL: Yes.

5 DR. KUSHNER: Yes, but they were not ---  
6 in Scotland we did not have that sort of problem.

7 MR. CAMPBELL: Before you left, had  
8 anything been achieved with the pharmaceutical distribu-  
9 tion and amphetamine misuse?

10 DR. KUSHNER: No.

11 MR. CAMPBELL: One thing you might be  
12 able to throw some light on is that these drugs are  
13 now only available through hospital pharmacies, and there  
14 would not seem to be as much amphetamine use taking  
15 place if it was not for smuggling and the illicit  
16 manufacturing. I wonder if you could give any inter-  
17 pretation of why it is happening?

18 DR. KUSHNER: I can only guess that the  
19 amphetamine users when they cannot get the intravenous,  
20 they will get the tablets and crush them up. I have  
21 one that would inject it with alcohol. If they cannot  
22 get one, they will get something else. I think it is  
23 a conditioned response.

24 THE CHAIRMAN: Thank you very much, Dr.  
25 Kushner.

26 (Applause)

27 THE CHAIRMAN: Mr. Hinsch, you have to  
28 leave --- I guess we all have to leave by 1:00 at least,  
29 but can you spare us a few minutes down here again,  
30 just to get as much benefit as we can from your experience



1 and knowledge in these cases, as part of the thing we  
2 are trying to achieve from this, is to find out --- just  
3 to try to get a picture of where we are at now, what  
4 changes have taken place in the last six months or so.  
5 I think we had questioned you about the cases of  
6 barbiturate use, opiate use and amphetamine use. I do  
7 not know whether you care to add anything to what Dr.  
8 Kushner has said about amphetamine use; . I mean from  
9 your own experience. Is there anything that your own  
10 observation of these cases, any light you could throw  
11 on these cases, social integration ---

12 MR. HINSCH: Yes, there is something  
13 that we are just beginning to do with amphetamine users  
14 at Merry-Go-Round, it is still in the planning stages,  
15 but it is intimated by everyone in the group, we are  
16 stealing a few ideas from the Alcoholics Anonymous  
17 people actually, and having some of their methods  
18 adopted to our usage, and as I say this is still in the  
19 planning stage.

20 DR. LEHMANN: What methods?

21 MR. HINSCH: I am not handling this, I  
22 could speak only on behalf of the person who is setting  
23 up our speed programme and could not be here, unfortunately.  
24 But these would be the group meetings, almost <sup>the</sup> psycho-  
25 therapy type and also we hope that these will work, but  
26 we really don't know. By the way, the group that is in  
27 Merry-Go-Round are calling themselves S.F.A. which stands  
28 for Speed Freaks Anonymous, and there is another  
29 translation too, but I will not go into that. Anyway,  
30 we are going to try this and see how it works, and we





1 are also going to try some better facilities, and someone  
2 will speak sometime later this afternoon; we are trying  
3 to get some people who will live in who want to get off,  
4 we are going to keep them there and have treatment  
5 continuously, rather than coming back say three times  
6 a week like they are doing now. And we are also going  
7 to try this with other users who want help, psychiatric.

8 THE CHAIRMAN: Thank you. The LSD  
9 patients accounted for about 62% or a total of roughly  
10 80 cases. What are the conditions of LSD use that you  
11 have had to deal with?

12 MR. HINSCH: Well, when we see them they  
13 are coming in on a bad trip, in a crisis state. Mostly  
14 it is within the first five times that they have used  
15 it. More experienced people we have not seen that much  
16 of, that is to say about 80% of the people coming in,  
17 it is on their first five trips, and with the others,  
18 we do not know what is happening. Also with the impurities  
19 that are in the acid that is available on the street, and  
20 the state of decomposition, they do not derive the total  
21 effect that they want from the drug, and there is stuff  
22 on the street available called Blue Double Dome and  
23 people had strychnine pains four days later.

24 DR. LEHMANN: They had what?

25 MR. HINSCH: They had strychnine pains  
26 up to four days later, and this is a severe case of  
27 strychnine in acid.

28 THE CHAIRMAN: Was any sample of that  
29 analyzed?

30 MR. HINSCH: There was a sample of it



1 analyzed, but I do not know the figures on it.

2 THE CHAIRMAN: Did they find strychnine  
3 base in the analysis of the actual drug, not an inference  
4 simply from symptoms?

5 MR. HINSCH: No, they had some of it  
6 analyzed, and it turned out to be a high percentage of  
7 strychnine.

8 THE CHAIRMAN: Who analyzed it?

9 MR. HINSCH: It was analyzed by the  
10 people from the Food and Drug Directorate.

11 DR. LEHMANN: When was that?

12 MR. HINSCH: It was in August.

13 DR. LEHMANN: Do you have any information  
14 as to why strychnine is from time to time added --- I  
15 can understand when talcum powder or something is added  
16 as a filler, but speaking of trips, why would they add  
17 strychnine. It is expensive.

18 MR. HINSCH: Speaking of street knowledge,  
19 strychnine adds a little bit to the colour of the trips,  
20 added effects. Whether it is true or not, I could not  
21 say. But this is street knowledge. And it is very, very  
22 poor at the best of times.

23 DR. LEHMANN: Is it street knowledge that  
24 strychnine adds to perception of colour and makes the  
25 trip more intense, and this street lore is then transmitted  
26 to the manufacturers and pushers and they are putting  
27 strychnine in?

28 MR. HINSCH: Yes.

29 DR. LEHMANN: What is your method of  
30 dealing with bad trips?



1 MR. HINSCH: Well, when we get bad trips,  
2 we get them to sit down and talk. We can only really  
3 reach them by talking or by playing music for them.

4 DR. LEHMANN: You concentrate mainly on  
5 talking down as your mainstay of therapy, and if this  
6 isn't effective, then you would give them sedatives,  
7 valium?

8 MR. HINSCH: Right.

9 DR. LEHMANN: And then are there some  
10 who cannot be managed and have to be referred to  
11 hospital?

12 MR. HINSCH: We have not had to do that  
13 as yet.

14 DR. LEHMANN: Have you had the facilities  
15 for keeping them overnight, for instance, on a very  
16 bad trip, or what do you do?

17 MR. HINSCH: We keep them in our office.

18 DR. LEHMANN: Overnight if necessary?

19 MR. HINSCH: Right.

20 DR. LEHMANN: Somebody sits up with  
21 them?

22 MR. HINSCH: That is right.

23 THE CHAIRMAN: Have you had any people  
24 who have expressed desire to get off LSD?

25 MR. HINSCH: Yes. More so in the last  
26 month, month and a half, than during the summer. Most  
27 people coming in on LSD during the summer just want to  
28 have a good time, and they do not worry about the long  
29 term effects. But some people in the last month and  
30 month and a half, now that school has started, they feel





1 that their school work is suffering because --- I do not  
2 know if that is true or not. It is another matter.

3 DR. LEHMANN: Do they find it difficult  
4 to let go of LSD?

5 MR. HINSCH: Some of them do. They find  
6 that they use LSD, like acid, sometimes three times a  
7 week when acid is available, and then when they have to  
8 go to school they really can't to do it, so it is a  
9 choice. Some of them drop out. Some of them decide to  
10 discontinue use of the acid. With some of them it is  
11 stopping drugs as a whole rather than just one drug.

12 DR. LEHMANN: Do you think these people  
13 come to you not so much because they find it difficult  
14 to get off the drug, but because they are seeking some  
15 other way of finding sense and meaning in their lives  
16 and motivations?

17 MR. HINSCH: Yes, a very high percentage  
18 of people coming in, we find that they are --- their  
19 whole lives are involved so much around drugs in the  
20 summer, and when they finally went back to school, it  
21 is just out of proportion.

22 MR. STEIN: One of the things that  
23 we have heard is that the business of talking people  
24 down, especially if it is done by an ex-user, can  
25 sometimes be as negative --- can have as negative an  
26 impact on the individual having a trip as if he might  
27 have gone to a hospital and the theory goes this way:  
28 the ex-user may have had some very bad experience himself  
29 during a previous trip, and he, at a time the individual  
30 is  
/ in the middle of his own trip, is very suggestable, he



1 receives a lot of picture images almost from the ex-user  
2 which may not have been there to begin with, but which  
3 may tend to really add a great deal of anxiety to a  
4 person in the middle of a trip. Now do you have any  
5 views on the ramifications and the talking down or  
6 difficulties with it?

7 MR. HINSCH: We have a small training  
8 programme. We have people when they first come in,  
9 they may do one or two shifts during the week, and they  
10 see what has to be done. If someone is going to be  
11 constantly interrupting the whole procedure, you are  
12 just not going to get anywhere with that person. You  
13 have to be somewhere where the person is going to get  
14 away from those influences that are causing him to  
15 "flip out". You have to keep him calm and reassure him  
16 that the whole thing is the effect of the drug. And  
17 it is just the effect of the drug that is doing it to  
18 him. Some people may use a different technique; some  
19 of them will try to get them interested in music, or  
20 some heavy philosophical discussion which I personally  
21 don't think are very good things to do. The philosophi-  
22 cal discussion can cause a person to get more dis-  
23 oriented to his surroundings than he is already, and  
24 the ability to concentrate, on acid, is not that high.

25 DR. LEHMANN: The example that was  
26 given was by someone who has a good deal of experience  
27 to people who have talk downs, and sometimes, as Mr.  
28 Stein just said, they would talk to somebody on a bad  
29 trip and say, "Well look, if you are going to feel your  
30 legs aren't belonging to your body anymore, don't worry





1 about it, it is only the drug". But they haven't felt  
2 their legs were not belonging to them, but they then do  
3 really feel it and they are worried even if they are  
4 told ahead of time that is what is going to happen. Now  
5 in your opinion, you could avoid this?

6 MR. HINSCH: They are told not to say  
7 that  
8 anything like/unless the person tells them this is what  
9 is happening. We try not to suggest anything to them.  
10 We prefer them to make such references first,

11 so we know what is going on in their heads and  
12 they know what is going on in our heads.

13 THE CHAIRMAN: What is the situation with  
14 solvents?

15 MR. HINSCH: Solvents are something that  
16 we don't see much of. I know there is a very high number  
17 of solvent users in the Halifax and Dartmouth area, and  
18 predominantly they are under the fifteen year old age ---  
19 fifteen years and under, junior high, up until, say,  
20 grade ten.

21 THE CHAIRMAN: But you did show six in  
22 your totals?

23 MR. HINSCH: Right.

24 THE CHAIRMAN: What did you do for them?

25 MR. HINSCH: Really, we didn't do that  
26 much for them, because they were brought to us by their  
27 parents, and they didn't want to come to us in the first  
28 place.

29 THE CHAIRMAN: There wasn't anything you  
30 could do for them?

MR. HINSCH: It was a matter that they felt



1 we were imposing on their lives, and we would rather that  
2 they come to us rather than we go to them. If we go  
3 to them, we are imposing on them rather than helping.  
4 That is the general picture. In a couple of cases we  
5 have managed to cut the use down.

6 THE CHAIRMAN: You have managed to cut  
7 the use down?

8 To  
9 MR. HINSCH: /a point where it is only  
once a week, rather than once a day.

10 THE CHAIRMAN: How did you do that?

11 MR. HINSCH: We really rapped with them  
12 for several hours on the whole procedure. Talked about  
13 their home life, school life, relationship with their  
14 friends and family, everything. And we tried to give  
15 them a new perspective on life.

16 THE CHAIRMAN: Excuse me, there is a  
17 gentleman at the microphone.

18 THE PUBLIC: Yes. I would like to bring  
19 up another subject on the same ground. (inaudible)  
20 had a talk for them at the School Board and planned  
21 his procedure and he put his job into jeopardy and  
22 wasn't allowed to continue. Now, after we did it, we  
23 got half way to it and we locked up our survey in that  
24 school vault, and there was another big bust. He again  
25 put his job on the line and we were allowed to continue.  
26 Now, we got our results, we weren't allowed to publish  
27 them and there was a conflict / with Dr. Whitehead who had  
28 done a survey in the school. We weren't allowed to  
29 publish ours because they might conflict with Dr.  
30 Whitehead. They were locked up for the summer. We tried



1 to get Dr. Whitehead, and we haven't been able to get  
2 him in respect to this, to the drug survey, we found  
3 that not only did the students take drugs here, but there  
4 are a few teachers that do take drugs, and these teachers  
5 --- we have no names. We asked for no names, but we  
6 suspect that since some of the younger teachers --  
7 they went through high schools and college, drugs were  
8 with them. Now also, if they have grown up in this  
9 drug scene, we suggest that they are still taking some.  
10 They are not on anything high, just marijuana. But still,  
11 it is an aspect to look at, that not only do most of the  
12 students take it, but that also a few of the teachers do.  
13 Not the majority, by far, of the teachers, but there are  
14 some. On the other hand, in one of our responses to the  
15 drug survey, we got a teacher who said he didn't or  
16 she didn't think there were any students in this school  
17 that took drugs. Now we all know, and I imagine he or  
18 she knew that there were. Now whether this teacher  
19 thought that the people, myself included, were doing the  
20 drug survey and were trying to find a person to sell it  
21 to, I can't tell you. But he just is either ignoring  
22 all the facts or he is afraid that he might get some  
23 wrong information.

24 THE CHAIRMAN: When you make a statement  
25 that some of the teachers are using it, do you know that  
26 as a fact or is that simply a conclusion you are drawing  
27 from their age?

28 THE PUBLIC: It is not a conclusion, it  
29 is a fact, that on this survey, we handed out some to  
30 the teachers, and that some have answered yes to marijuana.





1 THE CHAIRMAN: Thank you.

2 THE PUBLIC: I would just like to  
3 clarify something that was brought up earlier on. The  
4 reason for the use of strychnine in LSD is, to keep the  
5 LSD in a state where it is LSD and not broken down into  
6 ergot forms. It works down rapidly unless it is with  
7 something or with strychnine.

8 DR. LEHMANN: Did I understand you right,  
9 that the strychnine is supposed to keep the chemical  
10 nature of LSD intact?

11 THE PUBLIC: Yes, that is right.

12 DR. LEHMANN: Is there any evidence from  
13 which you know that?

14 THE PUBLIC: No.

15 DR. LEHMANN: That is another lore then,  
16 or that is one of the reasons given?

17 THE PUBLIC: Yes.

18 MR. HINSCH: Whenever the Food and Drug  
19 people have analyzed something, and whether it contains  
20 strychnine or not, it turned out to be ergot and not  
21 acid. They have never analyzed pure LSD in the Food  
22 and Drug lab here in Halifax.

23 THE CHAIRMAN: I think we should adjourn  
24 for lunch. This afternoon we will hear from Reverend  
25 Ray MacFarlane, Nova Scotia Federation of Alcohol  
26 Problems, and the Halifax Youth Communication Society,  
27 Mr. Watt, associated with the Halifax Youth Communica-  
28 tion Society and the Nova Scotia Home and School  
29 Federations, and Community Action Group of Truro. So  
30 we will have a very full afternoon, and I hope an



1 opportunity for discussion, and a contribution from  
2 others present. We are doing our best to try to make  
3 the most use of our day here, and to get all the  
4 benefit we can from those who are appearing before us,  
5 so we were lengthening our hearing this morning, and  
6 this afternoon we will have to compress/ <sup>a</sup> little more  
7 but come back here at 2:00 o'clock and we will  
8 certainly stay here as long as we can this afternoon,  
9 before we go on to St. Johns tomorrow.

10 I now adjourn the meeting.

11 ---Upon recessing at 12:50 p.m.

12 ---Upon resuming at 2:00 p.m.

13 THE CHAIRMAN: Ladies and gentlemen, we  
14 will now resume our hearing, and I will call upon  
15 Reverend MacFarlane of the Nova Scotia Federation of  
16 Alcohol Problems.

17 Excuse me, Reverend MacFarlane, please  
18 proceed.

19 DR. LEHMANN: Do you need the light to  
20 read?

21 REV. MacFARLANE: Ladies and gentlemen,  
22 members of the Commission, as has been indicated, my  
23 name is Raymond MacFarlane. I am the General Secretary  
24 of the Nova Scotia Federation on Alcohol Problems,  
25 working in the field of education and liaison efforts  
26 with interested church bodies, related government de-  
27 partments, youth serving agencies, etc., in the general  
28 field of education, more particularly on alcohol, but  
29 in recent years also on drugs. I began the term of  
30





1 office with the Federation on September 1, 1963 and I  
2 will be concluding my services with the Federation as  
3 of October 31st, 1970, which is not very far away.

4 Our Executive Committee authorized a brief and general  
5 presentation to your Commission in Halifax, the same to  
6 be reviewed and expanded and presented at our annual  
7 session on November 10th and forwarded to your office  
8 in Ottawa shortly thereafter.

9 I am therefore at this time presenting  
10 a broad outline on what will be expressed more  
11 explicitly in the brief to follow.

12 First, a word of commendation. We  
13 commend your Commission on its interim report made  
14 available to the general public a few months ago. Your  
15 analysis of the task assigned to you assures us that you  
16 plan to and have now under way a comprehensive objec-  
17 tive and definitive study of the social implications of  
18 the non-medical use of drugs in Canada and far beyond.

19 We are impressed with the informative  
20 interpretation of the drug abuse spectrum and the  
21 classification of the effects of specific drugs. This  
22 we have found to be helpful in our education programme.  
23 Your comments on multiple drug use will do much to  
24 assist us in establishing guidelines for education and  
25 for treatment programmes. We note that you advocate  
26 immediate and expanded remedial services to assist and  
27 safeguard initial youth experimentation with drugs. We  
28 heartily agree. We note that you plan an extensive  
29 study of drug dependency and treatment. Again we agree  
30 that this is an urgent aspect of the total problem. We



1 | note that your Commission recognizes that alcohol and  
2 | nicotine are drugs, the widespread acceptance and use of  
3 | which constitute a combination of social problems far  
4 | in excess of those resulting from the non-medical use  
5 | of drugs under discussion. Again, we support this  
6 | conclusion and have been stressing this fact in our  
7 | education and liaison efforts.

8 |               We would be less than honest were we not  
9 | to say that we are apprehensive both with respect to  
10 | certain aspects of your interim report and to popular  
11 | understanding in general of the non-medical use of the  
12 | drug problem.

13 |               For instance, we wonder how  
14 | representative what you heard at the first series of  
15 | hearings was of all the citizenry of Canada. We think  
16 | it natural that those that accept and participate in the  
17 | non-medical use of drugs would be prompt to make their  
18 | position on the issue known to you, while apathy and  
19 | lack of pertinent information would dissuade a much  
20 | larger segment of our population from appearing before  
21 | you. We find a widespread concern among educators, parents,  
22 | business and professional men, the clergy, etc., that  
23 | seemed not to be reflected in your interim report. We  
24 | note a general tendency in the report to overlook the  
25 | necessity of "government by law and statutory regulations  
26 | in favour of popular value judgments".

27 |               We agree that simple possession of  
28 | cannabis should be distinguished by law from the more  
29 | serious offence of possession for purposes of trafficking,  
30 | but we recognize a serious problem in determining what



1 a specific individual intends to do or does with what he  
2 or she has in their possession. Passing the product from  
3 person to person when no monetary reward is involved seems  
4 to be acceptable to your Commission. We feel that this  
5 defeats the purpose of the law, which, as we understand  
6 it, is intended to curtail the spread of the problem.  
7 Were this policy to be applied to the contributing to  
8 juvenile delinquency statute or, as we are more familiar  
9 with, to supplying a minor with liquor, etc., law  
10 enforcement in these areas would be seriously handi-  
11 capped. We note that you propose extending the same  
12 principle to regulations pertaining to all psychotropic  
13 drugs, some of which carry a potential for injury to  
14 some levels of society, even in small doses.

15 We wonder about the soft touch police  
16 procedures and enforcement provisions proposed with respect  
17 to entrapment methods, for instance, police entrapment  
18 methods, means of fines for possession, erasing of  
19 police records, etc. Will youth who benefit from such  
20 innovations today find them a thorn in the flesh when  
21 they eventually assume responsibility for a progressive  
22 productive society? We have some doubts at this  
23 point.

24 We like the approach your Commission is  
25 recommending for the establishing of community crisis  
26 centres where assistance and referral services can be  
27 provided on an emergency basis.

28 We appreciate the intensified and  
29 extended programme of research you have been and are  
30 now conducting throughout Canada, the United States and





1 elsewhere in search of basic facts upon which progressive  
2 recommendations can be made. We recommend a "go slow"  
3 policy on final conclusions as to what changes are  
4 indicated in the social, legal and remedial provisions  
5 relative to the non-medical use of drugs. This would  
6 be particularly true of cannabis and some of the other  
7 newer and lesser known drugs.

8 We urge that you provide in your forth-  
9 coming report an analysis of the total field of drug  
10 abuse. This would, we think, impress the youth of  
11 Canada with a challenge to adjust their personal habits  
12 to a chemically oriented society where in every aspect  
13 of social living we are affected by chemical action and  
14 reaction whether we like it or not. We live in or on  
15 a chemistry lab. We believe that youth will accept the  
16 challenge and as they themselves might say, "get with it".

17 Mr. Chairman, I appreciate the opportunity  
18 of this brief presentation to show what we have done.  
19 We will review this and expand it, and we will then  
20 forward a brief to you in more detail. Thank you.

21 THE CHAIRMAN: Thank you very much,  
22 Reverend MacFarlane.

23 We will have some questions and observa-  
24 tions. Dean Campbell?

25 MR. CAMPBELL: Reverend, one of the  
26 difficult questions here is to determine what the  
27 purpose of social policy should be. An English psychia-  
28 trist said to me this summer that when visiting one Europ-  
29 ean country he asked the officials there what the response  
30 of society should be to a woman who was so intoxicated



1 each evening that she couldn't cook her husband's dinner.  
2 And their view was that this was a private matter, it  
3 did not interfere with productivity. We would --- he  
4 went on to talk about England as a society that was  
5 prepared to accept very large casualties from alcohol,  
6 without using law to attempt to head this off, but once  
7 the casualty occurs to spend a great deal of money in  
8 rehabilitation and cure, a medical model for the  
9 alcoholic. Talking about other drugs, he spoke of  
10 English policy as being one that attempted to prevent  
11 the onset by the, as he put it -- "a heavily repressive  
12 law" was the phrase he used, but do little for the  
13 casualties once they occurred.

14 Now, you spoke of the need for law as a  
15 device of control. Is this a general principle that  
16 we should consider? To come back to this dichotomy, he  
17 would see law as a threat against all drugs in an  
18 initial phase. Would you generalize in this way?

19 REV. MacFARLANE: No, I think I would  
20 not, sir. First, I agree very highly with the person  
21 whom you are quoting there, that there is an entity in  
22 our society to more or less find a way out by treating  
23 the person who is suffering and has a serious problem  
24 with alcohol in some other way. I have myself never  
25 been able to go along with the "either/or" here. It seems  
26 to me an ounce of prevention in my judgment is worth a  
27 pound of cure. And really, as far as we are concerned,  
28 we are more particular about the field of prevention and  
29 we feel a lot in particular has to be done as far as we  
30 are concerned, and as I very much indicated, in providing



1 the so-called street clinics here that we speak about,  
2 or the crisis centres and so on. They are very necessary  
3 and very desirable. But it seems to me that the field  
4 of information, the kind of information that young  
5 people are more particularly involved in here, will  
6 accept the approach. But I think we cannot, above all,  
7 cannot ignore the fact that in a normal society where  
8 we have turned a right over to a particular department  
9 in our society, the law enforcement, we cannot afford<sup>not</sup> to  
10 give that serious consideration. We would need a  
11 replacement for what we do.

12 MR. CAMPBELL: Would you use the law  
13 in much the same way with alcohol as with cannabis and  
14 LSD?

15 REV. MacFARLANE: We advocate it very  
16 definitely. We make it very clear that we feel that  
17 there are certain members in our society which for  
18 various reasons, and they vary with different persons,  
19 who --- highway --- for instance, to get away from  
20 this altogether --- we could not get along without the  
21 highway --- with respect to the use of alcohol or the  
22 use of any drugs.

23 MR. CAMPBELL: Would you prohibit the  
24 use of alcohol the same way as you prohibit the use of  
25 cannabis?

26 REV. MacFARLANE: I am not so sure that  
27 prohibiting --- my reservation in prohibiting the use  
28 of cannabis would be that it adds to our society in  
29 another area, another problematic area. Now if it were  
30 possible to persuade our society that there are other





1 ways to enjoy a full, abundant, ready and happy life,  
2 other than stimulating ourselves with alcohol, I would  
3 like to see it. But we recognize in our society at the  
4 present time and probably for a long time, as indicated,  
5 that it is not possible. So I think we have to settle  
6 in part for what we have by way of the two popular  
7 drugs, alcohol and the use of tobacco. But I do not  
8 think that justifies in adding to it another.

9 MR. CAMPBELL: What reasons do you have  
10 in thinking that the law could be effective in an area  
11 like cannabis?

12 REV. MacFARLANE: I have no thought that  
13 it could be effective to the extent of eliminating the  
14 use of cannabis, either among the younger folk or among  
15 the others, but I am thoroughly convinced that what is  
16 accepted as practice by adults is quickly emulated by  
17 youth. And it seems to me that we are moving in the  
18 wrong direction if we do not recognize this, and if we  
19 attempt to discourage it. <sup>have</sup> I/no thought that it could  
20 be prohibited or completely eliminated, but I think there  
21 is a very good place by law for diminishing it, shall  
22 we say, for diminishing it.

23 THE CHAIRMAN: Are there any questions or  
24 observations from anyone to Reverend MacFarlane's  
25 submission?

26 I wondered, Reverend  
27 MacFarlane, if you could give us a little more detailed  
28 idea of your suggestion that in our final report --- the  
29 words I have <sup>are</sup> /that we "should present the total picture  
30 of drug use" ---



1                   REV. MacFARLANE: In my reference to the  
2 total picture of drug use?

3                   THE CHAIRMAN: Yes.

4                   REV. MacFARLANE: Well, I'm not so sure  
5 that I could do that, other than, I think, to recognize  
6 that there are many drugs that we do not talk about,  
7 that you did not talk about in your Commission report as  
8 being drugs that are abused, prescription drugs, such as  
9 amphetamines, barbiturates and so on, but they are not  
10 under discussion. Now, it seems to me that if we do not  
11 impress our generation with the hazards associated with  
12 chemicals that it is well to talk about all the chemicals  
13 and put them all in perspective and I think my contact  
14 with young people leads me to believe that they are  
15 ready to accept what seems to be reasonable and appro-  
16 priate, they do not want to be told what to do or forced  
17 to do, but --- this is probably what you had in mind when  
18 you asked the question about law --- but I think the  
19 broader we can make the discussion of chemicals as they  
20 pertain to use by the individual for self-medication and  
21 other uses, the better.

22                   DR. LEHMANN: Would you repeat that  
23 statement?

24                   REV. MacFARLANE: I feel that the broader  
25 we can cover this so far as the use of drugs and  
26 chemicals for self medication or self modifying one's  
27 mood or for anything you might choose, the broader we can  
28 make it, the more likely our young folk are to see this  
29 is part of an overall problem, and doesn't pertain  
30 merely to them but pertains nearly to everyone and the



1 abuse is as real and as serious among adults as it is  
2 among the younger members.

3 DR. LEHMANN: Our terms of reference  
4 were spelled out for us as having to be concerned with  
5 psychotropic drugs; that is, drugs which have an  
6 influence on mood.

7 REV. MacFARLANE: The first part of  
8 your question, again, I am sorry, I wasn't quite ---

9 DR. LEHMANN: Our terms of reference  
10 were given to us as having to be concerned with psycho-  
11 tropic drugs and the non-medical use only.

12 REV. MacFARLANE: I guess I wasn't  
13 quite alert to that as probably I should have been in  
14 terms of your reference. I understand that that is  
15 the terms of reference as it should be -- we have had  
16 in the workshop from time to time, had specialists  
17 in the field of alcoholism and drug abuse and  
18 so on working with us, and we have used from time  
19 to time a person who is an analyst for a pharmaceutical  
20 company, and he, I think, does an excellent piece of work  
21 in interpreting to the young people this whole matter  
22 of drug control. The drugs that are not the psychotropic  
23 drugs are as well a problem, and we have got to learn to  
24 live in a chemical society, and this is part of it, and  
25 I think in that light or in that perspective, young  
26 people are particularly more likely to accept this,  
27 whatever limitations may be there to get rid of them.

28 THE CHAIRMAN: Thank you. Any other  
29 questions? Any other questions or comments for Reverend  
30 MacFarlane? If not, then, Reverend MacFarlane, thank you





1 very much.

2 REV. MacFARLANE: Thank you very much,  
3 and we will forward something to you in detail later.

4 THE CHAIRMAN: I call now on Mr. Brian  
5 Phillips, Halifax Youth Communication Society.

6 Mr. Phillips?

7 MR. PHILLIPS: Mr. Chairman, members of  
8 the Commission, as was said, my name is Brian Phillips  
9 and I am the manager of the Federal Demonstration Project  
10 called Headquarters, run by the Halifax Youth Communication  
11 Society. We are funded primarily by the Department of  
12 National Health and Welfare, but we have also received  
13 funds from various local service groups, among them  
14 being the Halifax Junior League. So far we have received  
15 very little assistance or support of any kind from either  
16 the municipal or provincial levels. The provincial  
17 level has assisted us through their Department of Youth  
18 Agency, and we have negotiations going underway,  
19 and I will get into that a little bit later with the  
20 Municipal Governments.

21 Our project has been running since the  
22 first of June and we based the operation on the assumption  
23 that a very large part, if not the vast majority, of  
24 Canadian young people are alienated from the rest of  
25 society and will not make use of the services of  
26 established institutions and agencies and will not  
27 inform the society, until the situation has reached the  
28 crisis stage, when old services are no longer needed  
29 and the new ones are. This, I think, includes the  
30 whole educational system as a whole. Therefore we feel



1 that young people must be approached on their own terms  
2 and asked what their needs are and that society must be  
3 prepared to meet these needs or face the obvious results.

4 Headquarters is trying to do that job.  
5 This summer for example, we operated a hostel for young  
6 people who were travelling around the country. We feel  
7 that travelling in the summer time is a valid educational  
8 experience and at least as valuable as the traditional  
9 summer job, and has the potential to play a major role  
10 in helping to unify Canada. We tried to make that  
11 experience as positive as possible. The majority of the  
12 people we saw were intelligent, aware and concerned, both  
13 with what was happening in Halifax and in Canada in  
14 general. They had not conformed to the stereotype of  
15 dirty, unconcerned drug-taking hippies that the majority  
16 of our society seems to believe. They represent, we  
17 feel, the dynamic that can help make Canada a great  
18 country if they are given the chance.

19 This summer we also operated a referral  
20 centre for young people in the area providing liaison be-  
21 tween them and already existing services such as the  
22 Children's Aid Society and the Family Service Bureau.  
23 We also had available free twenty-four hour a day legal  
24 aid.

25 In addition to these services, we also  
26 maintained a twenty-four hour a day drug crisis inter-  
27 vention service. We managed to establish good  
28 relations with the police and the hospitals in this  
29 area and we were called upon by both groups to assist  
30 them in drug emergency cases. The major problem we en-



1 countered here was a lack of adequate referral services.  
2 A large percentage of our drug crisis cases were young  
3 people who had far greater problems than simply freaking  
4 out on acid. They required long term treatment by  
5 qualified and well informed psychiatrists, and such  
6 treatment is not available in Halifax. We had one boy  
7 who was with us for most of the summer/who freaked out  
8 more than a couple of times/ <sup>at our place.</sup> The last time he did it  
9 we went down to the V.G., Victoria General Hospital and  
10 took him down and we asked the hospital to have him  
11 committed. A few hours later he was on the street again,  
12 and the hospital obviously considered him to be just  
13 another acid freak-out. He left town a few days later  
14 and returned in a couple of weeks. Within a week/ <sup>of his return,</sup> he had  
15 jumped out of a window at Headquarters and he died a  
16 couple of days later. He was an extreme case, but we  
17 saw quite a few who ultimately might do such a thing  
18 as jumping out of windows, and there is absolutely  
19 nothing we can do except surface them. The community  
20 must provide adequate services in this area, such as  
21 psychiatric services and other <sup>that are needed</sup> services, and they have  
22 to be prepared to pay for the training necessary to  
23 adequately staff projects such as Headquarters so that  
24 we can do the job.

25 Another problem that we ran into this  
26 summer was lack of drug analysis services. A year or  
27 so ago we could get this done in Halifax, but for some  
28 reason we cannot get it done anymore. The only possible  
29 <sup>I can</sup> explanation/ think of is police pressure, and I can't think  
30 of any justifiable reason for that. It is well known that





1 most street drugs are cut with something, some of the  
2 substances being more harmful than others. If we knew  
3 what was in every drug sold on the street, it would be  
4 much easier<sup>for us</sup>/to treat crisis cases, some of which occur  
5 strictly because of the added substances. We could  
6 also make it known on the street exactly what was in a  
7 given drug and since no one wants to take a harmful  
8 drug, or buy a harmful drug, we could help ensure that  
9 only relatively pure drugs were sold on the street.

10 Towards the end of the summer it became  
11 obvious to us at Headquarters that the abuse of speed was  
12 the most important drug problem in Halifax. Up until  
13 this summer it wasn't much of a problem, but at the  
14 beginning of the summer, it started coming in in great  
15 quantities and it is fast becoming the most important  
16 problem as far as drug abuse is concerned, in Halifax.  
17 We decided we had to open a temporary street clinic in  
18 our building while we tried to get the funds to open a  
19 complete and well staffed clinic, and we came under  
20 heavy criticism for using known speed freaks to staff the  
21 clinic. But we felt that the problem was intense enough  
22 to justify this. We were not trying so much to put an  
23 end to speed use as we were trying to deal with the  
24 immediate medical and psychological problems involved. With  
25 problems such as hepatitis, mononucleosis, V.D.,  
26 collapsed veins, blood poisoning, abscesses, exhaustion  
27 and malnutrition, not to mention the intense mental  
28 depression involved in coming off speed, we felt that  
29 the situation was too critical to wait for adequate  
30 facilities, so we opened a clinic in cramped quarters with



1 a volunteer staff. Because of the conditions under  
2 which we were operating, because the building was so  
3 cramped, because the people weren't getting paid,  
4 because they were working twenty-four hours, twenty-four  
5 to thirty-six sometimes, the thing folded in a month  
6 and for the last three weeks we haven't been able to  
7 do anything. We just closed it down. And we are  
8 continuing to try to raise money to open an adequate  
9 clinic, but until we can do this there will be no  
10 facilities to deal with the speed problem in Halifax.  
11 And the problem is bad enough right now, but six months  
12 from now when it has been in town just that much longer,  
13 I think it will really become a really bad problem.  
14 Besides that, we had --- besides the fact<sup>that</sup>/there are  
15 other things to do under the terms of our Demonstration  
16 Project grant, and speed was just one small thing we  
17 could do, our facilities are not adequate and our staff  
18 is neither large enough or qualified enough to deal  
19 with the speed problem. In the long run, I feel it  
20 is doubtful whether anything can be done to get a  
21 confirmed speed freak off of speed, as I think most  
22 studies on the problem will probably indicate. The  
23 Trailer report on the use of speed in Toronto in 1969-70  
24 seems to point this out, I think.

25 I think that the answer to this and most  
26 drug abuse problems probably lies in projects such as  
27 ours which try to provide an atmosphere conducive to  
28 letting young people find and try out various alterna-  
29 tives to the established system. Right now our house  
30 is temporarily closed while we try to organize our winter



1 programmes. These include continuing our referral and  
2 counselling service, our free medical clinic which we  
3 ran all summer, and a drug crisis centre. In addition,  
4 we are becoming involved in the drug education programmes  
5 of various schools in this area and we are running into  
6 problems here because it is our policy to present the  
7 facts about drugs rather than become involved in the  
8 scare tactics that seem to be the content of most drug  
9 education programmes. It appears people are afraid to  
10 let us come in and tell the kids the facts. They just  
11 want us to come in and bring a few psychiatrists in who  
12 can report on brain damage over an extended period of  
13 time of speed use, etc., etc. So, we are also opening,  
14 hopefully within the next week, opening our house as a  
15 drop-in centre where young people can come and talk about  
16 whatever they want to talk about without worrying about  
17 who they say it to. We hope to have various recreational  
18 programmes for anybody who wants them, including creative  
19 arts, film making equipment in the form of video-tape, and  
20 qualified speakers who are prepared to come in and talk  
21 or lead discussion groups. But basically we are trying  
22 to wait until the kids come and find out what they want  
23 to do, rather than structure the thing before it gets  
24 going. In general, we hope to make available anything that  
25 young people want in order to express themselves, because  
26 we feel that by and large the facilities are not readily  
27 available and if they are, many young people are afraid  
28 to use them, or worse, feel their efforts will be  
29 stifled or stopped if they do. We are trying to break  
30 down the feelings of apathy, frustration, and useless-  
ness that many young people feel, and which manifest





1 themselves in the form of drug abuse of varying kinds.  
2 We feel that a large part of these feelings would be  
3 eased if the Government were to implement the interim  
4 recommendations of the LeDain Commission, because  
5 their failure to act in this area symbolizes to young  
6 people the hypocrisy and lack of concern that the  
7 entire society feels towards them.

8 In addition, we feel the LeDain  
9 Commission should exert any pressure it can to make  
10 drug analysis services available again and to exert  
11 pressure at all levels of Government, to encourage  
12 more and better drug education programmes, and to  
13 convince Government of the validity and value to the  
14 country of supporting projects such as ours which try to  
15 be oriented to and to a large degree run by young people.  
16 The old methods no longer work and the abuse of drugs  
17 will only be stopped, we feel, when these new methods  
18 are tried.

19 We would like to single out the abuse of  
20 speed from all other areas of drug abuse, and urge  
21 that the Government realize <sup>that</sup> it is by far the biggest  
22 problem and that money must be made available to deal  
23 with it wherever it appears, and it certainly has  
24 appeared in Halifax. We have half a dozen reports and  
25 a couple of confidential reports that we will be tabling  
26 later on. We haven't got all of our statistics  
27 together, but when we do them, we will make them  
28 available.

29 THE CHAIRMAN: Thank you.

30 MR. STEIN: What would you do with the



1 money, or you made a statement that you don't think that  
2 there is any successful programme to deal with heavy  
3 amphetamine users. But you are also suggesting the  
4 Government should give an all out priority to setting up  
5 of treatment facilities, and presumably they should give,  
6 I gather, your organization, amongst others, assistance  
7 in setting up some kind of programme or facility for  
8 treatment. What would you do in the way of a treatment  
9 programme if you had no financial difficulties? What  
10 would it look like?

11 MR. PHILLIPS: We have a  
12 couple of proposals for clinics which are still in the  
13 process of being prepared. It is very hard to say. I  
14 made the statement there is probably nothing I can do.  
15 I am not sure what can be done, but there are --- I feel  
16 that the use of speed is probably more a psychiatric  
17 problem, than a speed problem, and it is very hard to  
18 get to the bottom of it with just a speed clinic. The  
19 problems of the speed clinic to deal with would be,  
20 for example, the medical problem, of collapsed veins,  
21 abscess, exhaustion, malnutrition, that sort of thing.

22 MR. STEIN: Do you see an advantage to  
23 having a special clinic to deal with the specific medical  
24 problems connected with speed use, apart from having a  
25 clinic that also deals with the difficulty of excessive  
26 use of LSD? Do you want to have a separate category  
27 on each point?

28 MR. PHILLIPS: Not necessarily for each  
29 for certainly for speed. The sociology of the speed  
30 sub-culture is completely different from the drug sub-



1 culture in general. We have not done a hell of a lot  
2 about research on it yet down here, we have not been  
3 able to, we do not have the staff or the time or the  
4 money, but I read a report that Trailer did, which was  
5 referred to in 1969-70 and all the things that came  
6 out of that was that the speed sub-culture is a completely  
7 separate entity, and it should be, it has to be  
8 separated from the other areas of drug abuse.

9 MR. STEIN: I am a bit confused, because  
10 you also made the statement that probably <sup>there are</sup> some basic  
11 underlying --- I think you used the word psychiatric,  
12 difficulties of some sort that the individual may have,  
13 and I am baffled as to why it would be necessary to  
14 have special medical facilities to deal with what would  
15 be admittedly a different kind of ---

16 MR. PHILLIPS: I am sorry, I did not  
17 mean to distinguish between one house for medical and  
18 one house for psychiatric. It would be a clinic that  
19 would have to be staffed by qualified street workers to  
20 begin with, qualified psychiatrists, and also qualified  
21 medical doctors, because <sup>get to</sup> the psychiatric problems,  
22 first of all you have to go through the medical ones.  
23 And so if a kid comes in all strung out ---

24 THE CHAIRMAN: Excuse me. Do you see  
25 the specialization required for speed to be medical or  
26 rather understanding of the social culture, and the  
27 social context? Would the medical knowledge not be  
28 knowledge that could be applied to other kinds of drug  
29 use, aside from psychiatric knowledge? I am trying to  
30 find out why we need specialized services for speed.





1 MR. PHILLIPS: Well to begin with, the  
2 speeders are completely a different breed apart from any  
3 of the other people that exist in the youth sub-culture;  
4 in the drug sub-culture. The reports that I have read --  
5 this Trailer report points out that most of them, from the  
6 very beginning, before they even get into speed or hear  
7 about it, have feelings of paranoia , insecurity  
8 feelings, seem very depressed before they even begin,  
9 and they point out that the use of speed in the street  
10 community reinforces all these feelings once they get  
11 involved in the street community itself, there is very  
12 little chance of getting out of it. So at our house,  
13 for example, when we opened our speed clinic, we got  
14 the reaction on the street that nobody else would come  
15 near the place so long as we had speeders in there.

16 MR. STEIN: Let us take this in an  
17 analogous situation to heroin, not that they are similar  
18 but for a long time the feeling existed that you could  
19 not cure the heroin user unless you had a very highly  
20 specialized place where he became labelled as a heroin  
21 user, not a person, and where there was a development of  
22 highly rarified psychiatric and medical techniques to  
23 help him get over his heroin use. Now, I don't know if  
24 the shift has gone all the way in the other direction,  
25 but there has been a rethinking of this and the question  
26 has been raised as to whether the community mental  
27 health facilities ought not to be utilized for heroin  
28 users as well as for alcoholics and other kinds of drug  
29 users. In other words, one of the difficulties is that  
30 a kind of subtle labelling goes on that the individual is



1 told he is different and he feels different. A number of  
2 the characteristics you mentioned, paranoia and so on,  
3 are not exclusive to speed.

4 MR. PHILLIPS: True, but I think that  
5 perhaps the difference, at least the Trailer report  
6 pointed out, that speed users seem to feel that they  
7 are part of an elite --- they make that distinction  
8 themselves, and they don't like to mix with any other  
9 groups of people. Now, perhaps, a centre or clinic set  
10 up to deal with heroin abuse could possibly work with  
11 speed abuse. I do not know. All that I'm saying is  
12 that on the speed, what I am talking about is the young  
13 drug sub-culture, we are talking about maybe fourteen  
14 on up, they sort of see themselves as being different,  
15 and part of the reason that I would like to see a sort  
16 of a medical clinic attached to a psychiatric clinic,  
17 is because most of the speeders don't want to stop.  
18 The problems you see first of all are the medical ones,  
19 and you see all sorts of them coming in; in ten days  
20 we had fifty-seven different people come through our  
21 clinic. The first ten days of its operation. And very  
22 few, if any, wanted to stop speed. But the medical  
23 problems that they came to have treated, hepatitis,  
24 they wanted blood tests, just a place to crash. All I am  
25 saying is there has to be a place set up for them to do  
26 that, and what I am talking about when I say qualified  
27 people is maybe ex-speeders who are trained, etc., etc.,  
28 and can somehow subtly try to make the suggestion that  
29 perhaps you should stop speed, this sort of thing, but  
30 most of them do not want to. And the reason that we



1 would like a separate building in Halifax, is that if  
2 we get people to that stage, we can provide them, through  
3 Headquarters, with some sort of alternative recreational  
4 things that they could do. They could be plugged into  
5 any of the programmes that we have and they can do  
6 something like that. But the problem I think, is that  
7 most of them don't want to stop, and you can't convince  
8 them that they do, or that they should. And perhaps if  
9 we can get some sort of clinics set up where they know  
10 that they can come--they will not go to a hospital.  
11 They don't trust the doctors, the blood tests, anything.  
12 If they can be brought to a place that they know, there  
13 are a half a dozen or a dozen people working, maybe  
14 ex-speeders, who know what it is all about, they can  
15 perhaps channel them into programmes such as ours. It  
16 will require a lot of money and the speed thing is so  
17 new that perhaps some of the heroin aspects will work,  
18 but ---

19 DR. LEHMANN: You said "perhaps", and you  
20 also said the report seemed to indicate poor results.  
21 We heard today that literature from over the world  
22 indicates that it is extremely poor. But you are  
23 optimistic and say that all of these reports are not  
24 right. Although you place a lot in the speed report of  
25 Toronto, but all the other speed reports and attempts at  
26 dealing --- well, considerable sources on this issue,  
27 hoping to get them motivated to do something else. But  
28 all of them seem to have very poor results. Do you hope  
29 you would have better results anyway?

30 MR. PHILLIPS: I would think that the





1 projects at Headquarters would hopefully head off.  
2 Mr. MacFarlane was talking a while ago about prevention,  
3 and this is just a vague intuitive feeling that I have,  
4 that the problems exist at probably the high levels of  
5 society in the educational system, and perhaps there are  
6 some drastic changes to be made there. Perhaps a place  
7 like ours will show that kids like to come to a place  
8 like ours and like to do things that we can get going  
9 for them, so that they will not feel, "There is nothing  
10 I can do, why bother trying," etc., etc. We did a short  
11 little survey before we opened the thing, and we found  
12 that in school the kids at the rate of ten a week were  
13 getting into speed. Well, why? I don't know why, but  
14 I am saying that perhaps through liaison, a project  
15 like Headquarters, a separate speed clinic, perhaps we  
16 can come up with an answer. I agree it does not look  
17 very good. But I have this feeling that if we can head  
18 it off, then perhaps the ages of twelve and thirteen,  
19 perhaps by the time of seventeen, we can get something  
20 done.

21 MR. CAMPBELL: Has that prediction been  
22 borne out so far in the school year?

23 MR. PHILLIPS: We had to close our  
24 speed clinic.

25 MR. CAMPBELL: Have you any information  
26 that would suggest that it has?

27 MR. PHILLIPS: Well I was talking with  
28 one of the speed dealers in town the other day. We  
29 were talking about this speed clinic and he said he  
30 would like to see a clinic set up, because he said a lot



1 of people were having problems because of speed. He  
2 said he would do anything he could for anyone to stop  
3 speed if they would. He said I am not worried, for  
4 everyone that stops today, there will be two or three  
5 starting tomorrow. So his statement that he and other  
6 dealers in town are not worried --- I would say probably  
7 more than we predicted.

8 MR. CAMPBELL: Is this general through  
9 school population or particularly notable in certain  
10 areas, certain social classes?

11 MR. PHILLIPS: We have not been able  
12 to find that out yet. All the distinctions that we have  
13 been able to make are on the basis of age, and it  
14 started at about fourteen. We broke it down and we  
15 found that from thirteen to fifteen, and these figures  
16 we thought were conservative if anything, in the  
17 thirteen-fifteen year old group there are probably  
18 a hundred people, and this was in August, say, in  
19 Halifax they were shooting, but the dealers knew that  
20 the people we were involved knew about it. From  
21 seventeen to nineteen, about four hundred, and nineteen  
22 and over maybe five to eight. So what it amounts to is  
23 that there are as many people from thirteen to nineteen  
24 doing it as nineteen and above, which does not look  
25 very good, and I think that speed use is starting at the  
26 junior high school level, and going on from there.

27 MR. CAMPBELL: Do you have any feeling  
28 about --- do these individuals tend to start with oral  
29 amphetamines or do they move directly to intravenous  
30 feedings?



1 MR. PHILLIPS: I think about a year ago,  
2 they may have started with oral. But they are not doing  
3 that much any more. We had --- they are going direct  
4 right from the first time, probably.

5 MR. CAMPBELL: Beyond these figures you  
6 are citing, which I would take it refer exclusively to  
7 intravenous speed use, is there a very widespread oral  
8 amphetamine use as well, still?

9 MR. PHILLIPS: I would not think so. At  
10 lease not in Halifax. It is crystal <sup>injected</sup> / through the  
11 needle.

12 MR. CAMPBELL: And they use speed  
13 exclusively or acid as well and ---

14 MR. PHILLIPS: Oh yes. We had in the  
15 summer a lot of police pressure. In the summer there  
16 was a little marijuana and they would rather do grass or  
17 hash or something, but we had a freak-out at the hospital  
18 the other night where some kid had taken a hit of speed  
19 earlier, then dropped some mescaline and did speed later  
20 on in the evening.

21 MR. CAMPBELL: But he would be basically  
22 the speed user. His <sup>steady</sup> / drug would be speed?

23 MR. PHILLIPS: Yes.

24 MR. CAMPBELL: Now in this population,  
25 are there any cases of barbiturate use becoming signi-  
26 ficant?

27 MR. PHILLIPS: Not in this area, I don't  
28 think. I was talking to some people from the west  
29 coast, and barbiturates are being used heavily there,  
30 but they do not appear here. The only down that is being





1 used around here is valium, which is used almost exclusively  
2 after a run of some kind to come down. But that is the  
3 extent of it. We had one case this summer of somebody  
4 who we came down who was using downers and nothing else,  
5 or primarily downers, barbiturates.

6 MR. CAMPBELL: I know you did not say  
7 --- I know you said that you really did not understand  
8 why the speed phenomena. Do you see any insight,  
9 pressures, this kind of thing?

10 MR. PHILLIPS: In general terms, yes  
11 probably, but it has to do--like, I know some of the kids  
12 that are involved at our place for example, and I know  
13 some of their family backgrounds. And it has just been  
14 terrible. It would not make any difference if there  
15 was drugs around or not, they would still be in some sort  
16 of trouble. Yes, I think bad family, bad backgrounds,  
17 general lack of motivation, nobody to suggest to them  
18 on the way while they were growing<sup>up</sup> that there is  
19 something else to do, something else you can do besides  
20 going to school and doing that. And most of them are  
21 sort of fed up with that. When they get into drugs or  
22 speed particularly, that just goes out the window.

23 MR. CAMPBELL: Why speed? The person of  
24 this background that you are speaking of, you could  
25 hypothesize he might go to alcohol, he might go to  
26 acid, he might just get high on grass or he might go to  
27 speed. What is there about speed?

28 MR. PHILLIPS: Well, I think that to  
29 begin with you can make a distinction between alcohol  
30 and the types of drugs that you are talking about in



1 your report for example, hash, grass, speed, etc. Most  
2 of them seem to be motivated toward the type of philoso-  
3 phy that people who are doing grass, etc., etc., expound  
4 the Love, Peace, and the Love to them means  
5 high school, football games etc., and that is why they  
6 don't go to alcohol. Now, why don't they go to grass  
7 or something, or acid? A lot of them maybe do go to  
8 acid. Why do they go to speed? I think it is because,  
9 as I said, probably most of them are depressed to begin  
10 with, insecure because of their family background; just  
11 intensely negative about themselves and about the society  
12 and about life in general, and I think a head of speed  
13 just takes you away up and beyond all of that.

14 MR. CAMPBELL: So you are suggesting that  
15 in these schools we have a population very much at risk  
16 because of its depression, because of its insecurity,  
17 that is now very much at risk once speed becomes intro-  
18 duced into that population?

19 MR. PHILLIPS: Yes, I think so, without  
20 much of a doubt as far as I can see.

21 MR. CAMPBELL: Would I be right in  
22 remark in interpreting your/suggesting speed is going to run through  
23 that population, however large it happens to be?

24 MR. PHILLIPS: Oh, there is no doubt  
25 about that. If that group exists, or whoever exists in  
26 that group, I would think yes, would go into speed  
27 before long.

28 MR. CAMPBELL: Do you see it being  
29 limited to that group, that it will run through it and  
30 at that point stop?



1 MR. PHILLIPS: Pretty well.

2 THE CHAIRMAN: You are not suggesting  
3 under the leading questions of my colleague that every-  
4 one who has these characteristics will necessarily take  
5 up speed?

6 MR. PHILLIPS: Not necessarily, but I  
7 think the chances are pretty good.

8 DR. LEHMANN: How is it that in other  
9 communities where an equal proportion of these under-  
10 privileged young people exist, there is very little of the  
11 speed problem? For instance, in Vancouver there is  
12 really very little. Vancouver probably has a considerable  
13 proportion of these underprivileged depressive young  
14 people, and yet there is very little speed and it is not  
15 because they are ---

16 MR. PHILLIPS: I suppose it depends on  
17 how you define underprivileged. I am not saying under-  
18 privileged.

19 DR. LEHMANN: Depressed you said.

20 MR. PHILLIPS: I am saying young people  
21 who have a negative outlook on themselves and on society.  
22 The speed user lives for today and that's it. The only  
23 thing he lives for is popping another head of speed.

24 DR. LEHMANN: Do you think there are more  
25 people living in Halifax with a negative outlook in  
26 Halifax or in Toronto than any other city in Canada?

27 MR. PHILLIPS: It seems there are a lot  
28 more in Halifax for some reason. The percentages of the  
29 use of speed in Halifax, as far as we can tell, is a far  
30 higher proportion.





1 DR. LEHMANN: That is a fact, but the  
2 young people with a negative outlook, this is an  
3 inference you draw that there are more here than anywhere  
4 else?

5 MR. PHILLIPS: Well, right, based on  
6 what we have seen, on the numbers, the relative numbers  
7 of speed users. I don't know. I can't base this on  
8 anything. I am saying that this, from what we have  
9 seen, and what we have heard, speed dealers, etc., etc.,  
10 that this is what seems to be the case. And if that  
11 isn't the case in Vancouver, I have no real answer for  
12 that. Perhaps the fact that the culture exists, that  
13 there is a large permanent culture out there, drug  
14 sub-culture and perhaps that all pulls them together, and  
15 it means they don't feel underprivileged, that they do  
16 have something, they have a society to live for, but  
17 that certainly isn't the case here, and I doubt very  
18 much if it is the case in Montreal or Toronto, and  
19 certainly not in the smaller communities outside these  
20 big cities, the small communities around the country.  
21 I have been talking to some people in Bedford, which is  
22 some nine miles out, and they have been telling me they  
23 don't have to worry about speed or anything else out  
24 there, because they aren't anywhere near the big city,  
25 and they are unsophisticated and they don't have to  
26 worry about that, and that is the type of attitude that  
27 has got to be combatted. I think quite obviously anyone  
28 who feels that way, I don't think their children can  
29 possibly feel that these people care about them or are  
30 interested in doing anything for them, and this is the



1 type of attitude that I think will probably breed the  
2 use or more speed. Not just speed, but the use of drugs  
3 of all kinds, but particularly speed.

4 DR. LEHMANN: Have you any idea why  
5 a speed pusher would be interested in pushing the clinic  
6 for speed users? Does he think that they ought to learn  
7 how to use speed wisely?

8 MR. PHILLIPS: That is one factor.

9 DR. LEHMANN: Really?

10 MR. PHILLIPS: We had a lot of people  
11 when we opened our speed clinic who felt the extent of  
12 our clinic should be teach people how to live with  
13 speed. In other words, we should try and educate  
14 people or speed freaks, the fact they should be using  
15 vitamins every day, and they should be forcing themselves  
16 to eat and sleep; that they should be boiling their syringes  
17 before they use them; they should be doing everything  
18 they can. And that should be the extent of what we  
19 should do, because there was nothing else we could do.  
20 Well, we decided there probably was something more we  
21 could do, but the dealers-it is very hard. This Trailer  
22 report brings something out, and I think it is proved to  
23 be the case down here. The users --- if someone in the  
24 speed culture wants to try and stop and it was certainly  
25 borne out in our clinic on a couple of occasions, that  
26 everyone in the community is gung ho to help him. For  
27 some reason they just get out there. They will do  
28 everything they can. The dealers will cut them off,  
29 nobody will sell him any speed.

30 DR. LEHMANN: The dealers will cut them



1 off?

2 MR. PHILLIPS: The dealer will cut them  
3 off. And this is one thing this dealer said; he wanted  
4 to run our clinic, suggested he would run it, and he  
5 said if anybody wanted to stop speed that he would  
6 ensure that that person was cut off from speed in the  
7 city, <sup>he</sup> and/could probably do it. It probably is done and  
8 has been done. I know as a waiter cuts someone off in  
9 the tavern, they will cut a speed user off if they are  
10 beginning to hurt themselves.

11 MR. CAMPBELL: You talked about two  
12 things there; you talked about the dealer wanting to  
13 help the person who wants to get off, and then you go  
14 on to say ---

15 MR. PHILLIPS: I am not talking about  
16 the one who wants to get off. The dealer will do that.  
17 They will also do it if someone has got themselves  
18 messed up on the stuff of their own accord.

19 THE CHAIRMAN: What kind of support is  
20 there for the notion there can be a wise use of  
21 intravenous amphetamine?

22 MR. PHILLIPS: Among whom?

23 THE CHAIRMAN: By anybody. Is that a  
24 serious proposition that there can be a wise use of  
25 intravenous ---

26 MR. PHILLIPS: Not as far as we are  
27 concerned, but as far as the speed freak is concerned  
28 there is. They really feel they can live with speed  
29 for the rest of their life, if you make sure you get  
30 lots of sleep and lots of vitamins and don't get hepatitis,





1     etc., etc.

2                     MR. CAMPBELL: Are your remarks, remarks  
3     pertaining to Halifax or the Halifax-Dartmouth area,  
4     or is the use of speed increasing throughout the  
5     province as well?

6                     MR. PHILLIPS: Mainly I am talking about  
7     Halifax-Dartmouth. The use of speed isn't really  
8     critical throughout the province yet, but from what we  
9     have been able to find out, from what dealers have  
10    said, and from what other people have said and what we  
11    are able to find out from people coming in from the  
12    smaller towns, it is probably just a matter of time.  
13    Like I said, before this summer, the speed use in this  
14    city wasn't really that great, but this summer did it  
15    and so we are that much behind Toronto and Montreal,  
16    and New York, Vancouver, etc., etc. But it's just a  
17    matter of time before I think it goes out into the  
18    other areas. And heroin also is becoming a problem here.  
19    We have been told some of the dealers are cutting their  
20    speed with heroin, and there is heroin being dealt on  
21    the streets. It seems to be a question once you hear  
22    about a drug, it's just a matter of time before it's  
23    here.

24                    THE CHAIRMAN: What is the kind of  
25    "point of contact" for the person who is about to take  
26    up speed? What is the typical kind of contact which  
27    they would have to offer them the opportunity to begin  
28    intravenous injections?

29                    MR. PHILLIPS: It is hard to say.  
30    Probably, simply, they know somebody who is shooting speed.



1 If you have tried everything else, you go to your friend  
2 and say, "I would like to try speed" and he says, "Sure  
3 thing". And away you go. It is as simple as that.

4 But then here we have some sort of confidential reports  
5 that we have compiled that will sort of point the  
6 answer to that question out a little more clearly.

7 MR. CAMPBELL: They will be available to  
8 us?

9 MR. PHILLIPS: Yes.

10 MR. CAMPBELL: You mentioned speed cut  
11 with heroin. Is this what is said or ---

12 MR. PHILLIPS: This was a rumour.

13 MR. CAMPBELL: There is no analysis to  
14 back that up?

15 MR. PHILLIPS: We couldn't get it if  
16 we wanted it.

17 MR. CAMPBELL: What about the attitude  
18 to heroin? Do you see a population locally that, if  
19 heroin becomes more readily available, will be the buyers  
20 of it?

21 MR. PHILLIPS: I would imagine. Yes.  
22 There doesn't seem to be much question about it. I don't  
23 know how large it would be, but there certainly would be  
24 a population that would move on to heroin if it was  
25 available and if they can get it fairly cheaply.

26 MR. CAMPBELL: What in general would be  
27 the attitude of the people you see towards heroin?

28 MR. PHILLIPS: Well, I am just trying to  
29 think of how I would define it. It would probably be ---  
30 among the people who would possibly use it? It would ---



1 MR. CAMPBELL: There are probably going  
2 to be several attitudes here, and I would like to elicit  
3 what these varying attitudes are.

4 MR. PHILLIPS: It is very hard to say.  
5 Probably just one of apathy, that "It is here, it is  
6 a nice drug; I might as well use it".

7 If anyone is motivated to use heroin --  
8 if speed wasn't enough, if acid wasn't enough, if  
9 grass wasn't enough, I suppose -- I don't know. To  
10 my knowledge, at any rate, heroin addicts down here --  
11 at least one or two, but I have absolutely no contact  
12 with that at all.

13 MR. CAMPBELL: When you have heard  
14 people make statements that heroin is a "nice drug",  
15 what would be the context of "nice" here?

16 MR. PHILLIPS: The context would be  
17 one, you could function if you wanted to, two, the  
18 feelings of euphoria would be intense, as intense as  
19 they possibly could be; nothing would bother you; you  
20 wouldn't care about anything, you would have no  
21 worries; that sort of thing. It would just be a  
22 complete euphoria sort of thing. You would be just  
23 sitting there sort of stoned and if you didn't want  
24 to do anything, you wouldn't, and if you wanted to,  
25 you would; you wouldn't care about anything. And I  
26 have talked to a couple of people on heroin, and that  
27 seems to be their attitude, at any rate.

28 MR. CAMPBELL: The risk of addiction  
29 and the public knowledge of what addiction means is  
30 not a deterrent?





1 MR. PHILLIPS: I don't think so. In  
2 fact I would think it would be assumed they were going  
3 to become addicted and that would induce one more of  
4 the "I don't care less" attitude.

5 DR. LEHMANN: Is there a feeling mixed  
6 in with this that when they become addicted or when they  
7 join the speed community, culture, and so on, that  
8 they are also doing some sort of beneficial, "construc-  
9 tive" <sup>thing</sup> /in opposing the establishment? In other words,  
10 it is an activist movement if they become hooked on  
11 heroin?

12 MR. PHILLIPS: In a very subconscious  
13 way, perhaps. But yes, I wouldn't go so far --- it  
14 wouldn't be an activist movement, but yes, they would  
15 recognize that they are apart from the rest of society  
16 which is bad, etc., etc., etc., and therefore, "Who cares  
17 and what does that society matter anyway." It would be  
18 that kind of an attitude.

19 MR. CAMPBELL: I think that it  
20 is sometimes suggested that one type of attitude -- one  
21 thing nice about heroin is it is a superb revenge on  
22 people close to you; now, granted, the stigma of heroin;  
23 and if you really want to hurt your parents, addiction  
24 is a fairly efficient way of doing it. Do you have  
25 any feeling among the people you see at risk to heroin  
26 addiction, this sort of need for a very aggressive  
27 response to people?

28 MR. PHILLIPS: In fact, the attitude  
29 seems to be the reverse to that, at least with the use  
30 of speed, and, well, having to do with the attitudes of



1 things and the attitude is let's not let our parents  
2 find out, and let's do everything we can to make sure  
3 the parents don't find out. So it doesn't seem to be  
4 a reaction to that type of attitude.

5 THE CHAIRMAN: What is the occupational  
6 status of the speed users that you have seen? You  
7 have mentioned about fifty-six cases as I recall, and  
8 you made estimates totalling about 1,000. Of those you  
9 have seen, what was their occupational --- broadly  
10 speaking, distribution by occupation?

11 MR. PHILLIPS: To a large degree, their  
12 occupations are nothing. They are not doing anything,  
13 although some are going to school or are trying to,  
14 but unless they get into the speed, they will probably  
15 drop out. They have a couple of kids that are going to  
16 be shipped to Europe, that sort of thing. They are not  
17 doing anything at the time, and if they are, they stop  
18 it. It is a sort of a fantasy type of thing.

19 MR. STEIN: Do they come from all  
20 economic and social ethnic groups in the community?  
21 Is it a complete cross-section?

22 MR. PHILLIPS: I would not say it is  
23 complete but it certainly spans the whole of Halifax.  
24 We know speed freaks whose parents are high up in the  
25 echelons of Halifax society, and we also know freaks  
26 from the bottom.

27 MR. STEIN: Blacks and whites?

28 MR. PHILLIPS: Uh-huh. We have not run  
29 into any blacks at our place for the simple reason, I  
30 think that there is a distinction because we are in the



1 south end and they are in the north end. Perhaps if we  
2 could get a speed clinic going, we could get that going.  
3 I have heard there are speed freaks in the north, but  
4 they have not surfaced at our place in any way.

5 THE CHAIRMAN: If, as you suggest, the  
6 underlying causes of speed use is only a symptom, go  
7 back into the social environment and sense of helplessness  
8 in various situations, family, school, why do you  
9 think that a specialized treatment facility, adequately  
10 staffed could make<sup>a</sup>/significant impact on these causes?

11 MR. PHILLIPS: I am thinking in idealistic  
12 terms, perhaps. I am thinking that if you are interested  
13 or if there is an interest to try and get every single  
14 kid who is addicted to speed psychologically, or  
15 however the drug addiction occurs, to stop using that  
16 drug, then I would think that the type of facility that  
17 you are talking about is a facility where you have maybe  
18 one psychiatrist to every five people, that you are  
19 talking about a long, long term thing. It is a long  
20 term rehabilitation, and I think it is possible that you  
21 have to have some very, very cool psychiatrists. They  
22 would have to be willing to spend a long time. You could  
23 not have a situation where you could send all the freaks  
24 to one psychiatrist. Though I was talking to one who was  
25 doing group therapy, and they were having some success  
26 there, so perhaps that would/ basically speaking, you  
27 are talking about a long, long term project with a large  
28 ratio of speeders to qualified psychiatrists and it  
29 probably could not be done as long as the clinic is in  
30 a setting close to the speed community. In other words,





1 it is absolutely impossible for us, for example, to open  
2 a house in Halifax without a half-way house somewhere  
3 else and expect to get the kids off speed without them  
4 going back on it every night. The pressures in that  
5 community are too great to expect them to respond.

6 THE CHAIRMAN: Should we consider some  
7 form of compulsory treatment to segregation of speed  
8 users?

9 MR. PHILLIPS: Compulsory treatment simply  
10 won't work.

11 DR. LEHMANN: How do you know?

12 MR. PHILLIPS: Well, in the sense that  
13 you cannot force the speed user to stop using speed.  
14 You could, say, if your tests show that he is using  
15 speed and then you will simply sign a Commission order  
16 and send him away to a hospital for a year, perhaps you  
17 could get to him in a year, but more than likely you  
18 would simply alienate him even further, and when he came  
19 back he would be out with a vengeance.

20 DR. LEHMANN: Well, suppose there would  
21 be --- actually, we do not know of any treatment procedure  
22 that would be successful even with that high ratio, so  
23 therefore your assumption that compulsory treatment, let  
24 us say for six months --- I think they found in Scandanavia  
25 that the only ones that had a chance were the ones who  
26 stayed a little more than eight months, suppose a year  
27 or so compulsory treatment would be legislated. We  
28 still would not know that it would be successful. But,  
29 you seem to assume that it would not be because it would  
30 be forced. Now, you really have no reason ---



1 MR. PHILLIPS: About the only reason I  
2 have for making that statement is that every speeder  
3 that has come to us and talked about the speed clinic or  
4 anything else, is adamant about one thing, and that is  
5 that you cannot force anyone to quit speed. So,  
6 therefore, I am positive that if you could put somebody  
7 away for eight months to two years, <sup>would</sup> you have time to  
8 work for it. I for one <sup>not</sup> would be in favour of that on  
9 moral grounds, but it would be a life's work.

10  
11 DR. LEHMANN: You would not be in favour  
12 on moral grounds. Let us suppose that it could be  
13 shown that it could be effective, 50% or 60% effective,  
14 would you still be against it on moral grounds?

15 MR. PHILLIPS: Probably not as much ---  
16 I think no, if you could show that it could be  
17 successful to that extent, I --- I just don't like the  
18 idea, personally, of locking somebody away, but if it  
19 worked to that extent, I would imagine that I would  
20 probably change my mind, yes.

21 DR. LEHMANN: I see.

22 THE CHAIRMAN: How important is the  
23 existence of a group of users in the decision to start  
24 speed, in the introduction of a new person to speed?  
25 Some people say <sup>there</sup> / is an epidemic type of action that  
26 takes place, in effect, particularly because of  
27 using the needle, you really have to be introduced to  
28 it by someone who will get you over that needle inhibition.  
29 From that they kind of generalize an epidemic character-  
30 ization of the whole phenomena. And then they say, they



1 | conclude that in order to cope with it that you have to  
2 | remove the speed user some way from contact with others  
3 | who are at risk. And from there flows this notion of  
4 | segregation and some form of confinement, whether it be  
5 | called treatment or --- what is your feeling about the  
6 | importance of this group of people; importance as a  
7 | means of introducing others?

8 | MR. PHILLIPS: I don't know. I have not  
9 | heard anybody say that "The reason I am not even thinking  
10 | about it is the needle." I don't know. I think it is ---  
11 | the introduction is more the social angle of the user,  
12 | perhaps the person who is going to become one. I have  
13 | never heard that argument before, but I think, yes ---  
14 | the community would certainly be very important. The  
15 | person who is going to use it would become acquainted  
16 | with the speed community before they start using it,  
17 | and they even hang around with these people for a long  
18 | time, maybe for a few months before they start using  
19 | the needle to any degree. But in terms of helping them  
20 | over that initial fear of sticking a needle in their  
21 | veins, it may be important, but to me it does not seem  
22 | of primary importance, really.

23 | DR. LEHMANN: I presume you know a little  
24 | about behavioural therapy, conditioning people against  
25 | certain specific undertakings or behaviour? Now let  
26 | us assume again --- this is again a supposition --- that  
27 | one would try behaviour therapy not against speed but  
28 | against the use of a needle, and one would, through  
29 | aversion conditioning, create a situation where somebody  
30 | just when he sees a needle would shudder away and run.





1 Now what would happen to speed freaks who are still  
2 going to have the need to get the relief or whatever  
3 that they --- the high of the hit, rush? Would they go  
4 to other drugs, would they take it by mouth, would they  
5 simply blow their top? What do you think would happen?

6 MR. PHILLIPS: We had one case at the  
7 clinic and every time I quote it-- with one girl in our  
8 house--there was no way of taking it, there was not a  
9 needle or anything, and she took a can opener and  
10 pierced the vein and dropped it in.

11 DR. LEHMANN: That could still be con-  
12 ditioned away, any kind of piercing of the skin. But  
13 then what would happen?

14 MR. PHILLIPS: If you did that and nothing  
15 else, if you did not provide some sort of psychiatric  
16 counselling or long term --- I am afraid they would blow  
17 their top, you are right. Sure. There would be a mental  
18 breakdown in a matter of a few weeks probably, unless  
19 you kept them supplied with downers all the time.

20 DR. LEHMANN: So the best you could do  
21 then is substituting it with a somewhat more acceptable  
22 drug, getting away from the needle, but you would have  
23 to give it by mouth or give downers?

24 MR. PHILLIPS: There would be alternatives  
25 but whether they would be better or not that is debatable.  
26 But if nothing else were done, no alternatives were  
27 given, I think that it would result in a nervous break-  
28 down probably in a few weeks.

29 THE CHAIRMAN: Any other questions or  
30 comments to Mr. Phillips?



1 Yes, would you like to use the microphone  
2 please?

3 THE PUBLIC: Yes Mr. Chairman. I am a  
4 youth worker with Brian on the same project, the  
5 Headquarters operation, and I think there is a whole  
6 area that you have touched on that should be explored  
7 in greater detail. And that is the motivation of the  
8 speed user and why he gets involved. The area I am  
9 speaking of particularly is not so much personality  
10 problems or family background, but the feeling of  
11 political, social apathy. To give you an example, there  
12 was a fellow through our hands this summer who told  
13 someone quite recently that he was using speed because  
14 he could not do anything about the war in Viet Nam.  
15 Now he was seventeen, this is the logic of a teenager.  
16 But I think this whole apathy, sense of powerlessness  
17 is a pretty large factor, and I find it consistently,  
18 if not ignored, sort of swept to one side by people  
19 examining the phenomena. Also, the factor about people  
20 examining the implications of speed use, right now in  
21 Halifax this is not in fact taking place. The speed  
22 community is very uncohesive. There is not a great  
23 change of information or the ideology that "We like  
24 doing speed." So it is not really a rebellion against  
25 our society or even a distaste for it. But this is a step  
26 in the progression and I am offering for your considera-  
27 tion the hypothesis that speed use, initially, as Brian  
28 said, is a subconscious reaction to society and contrary  
29 to what I have been hearing lately, is that there is a  
30 heavy speed use through radical, political groups in the



1 States and I refer particularly to the Weathermen who  
2 are well known speed users in the States. So, perhaps,  
3 what I am saying is that you should look into areas that  
4 would allow for alternative expressions of this energy,  
5 aside from speed usage. You see one of the things that  
6 we are trying to do there is provide a recreational  
7 programme which is <sup>a</sup>euphemism for some sort of way the  
8 speed user could relate to problems upsetting him, and  
9 problems in general.

10 MISS BERTRAND: Do you feel or believe  
11 there is a political energy which is there to be used  
12 in potential speed users?

13 THE PUBLIC: Well, the energy is there  
14 as far as I can see, however, it is not reaching  
15 expression yet simply because, well not simply, but  
16 simply because factors in the community -- factors in  
17 the community don't allow for this movement to start.  
18 As I say, it is a rather new phenomenon for Halifax yet,  
19 Give it a few years as it has had a few years in San  
20 Francisco and I think this energy will emerge.

21 MR. STEIN: It has had a few years in  
22 San Francisco and it is apparently --- well, I hesitate  
23 to make this over simplification but there seems a  
24 definite impression in San Francisco this summer that  
25 speed use had been cut down considerably and was being  
26 replaced by those who were heavy drug users with heroin.  
27 The question that I was going to ask you is, what is  
28 the basis of your statement that political activist  
29 groups in the United States are known speed users? What  
30 do you base that statement on?





1 THE PUBLIC: Through conversations with  
2 political activists in the United States.

3 MR. STEIN: You are quite convinced this  
4 isn't just an exceptional ---

5 THE PUBLIC: No. Of course, I can't be.  
6 As far as I know, there is widespread thought that  
7 speed is used in activist groups. In demonstrations for  
8 key periods, speed was used.

9 MR. STEIN: You mean it may be the same  
10 way a businessman may take a couple of pills in the  
11 morning as a pep thing. But, I am talking about  
12 chronic amphetamine users, intravenous injections.

13 THE PUBLIC: You are right there. They  
14 try to discourage chronic speed use because of the  
15 deleterious chronic effects, but it is used occasionally  
16 for key periods.

17 DR. LEHMAN: Do you mean it is used as  
18 a stimulant or it is used for the rush and the hit, the  
19 feeling of tremendous power that comes of it? In that  
20 case, according to your theory, as I understood it, it is  
21 one of the expressions for a need and to fulfill this  
22 need for more power. On the other hand, if it is used  
23 for a pep pill, that would simply mean they are very  
24 fatigued by all the things they are doing and they need  
25 a little more energy and it is a stimulant. What do  
26 you mean, as a stimulant or as an end in itself?

27 THE PUBLIC: I am not sure on that point.

28 DR. LEHMANN: Surely the experience on  
29 the thing you are talking about, on the political thing,  
30 is an enjoyable experience, but the survival value of it, /  
the sustaining



1 value of it, is also present. Do they use it by mouth  
2 or do they shoot it?

3 THE PUBLIC: Of the particular type we  
4 are speaking of, as far as I know, this would be more  
5 injecting.

6 DR. LEHMANN: Injecting?

7 THE PUBLIC: Yes, intravenous.

8 DR. LEHMANN: This would be very large  
9 doses so that goes beyond just stimulation.

10 THE PUBLIC: The people using this just  
11 in the context of getting speed for political events,  
12 are not using extremely large doses, because as you  
13 well know, extremely large doses render you incapable  
14 of functioning.

15 DR. LEHMANN: But if they use it  
16 intravenously in practically always large doses, to get  
17 the stimulating effect, you take it by mouth in much  
18 smaller doses, you don't shoot it.

19 THE PUBLIC: Well, by adjusting dosage  
20 --- let's say larger than the medical dosage but not as  
21 large as the, shall we say, apathetic speed freak in a  
22 communal situation. You can get both effects, that is  
23 the stimulation, the initial rush and the stimulation  
24 over a period of time.

25 THE CHAIRMAN: Thank you.

26 Any other questions or observations with  
27 respect to Mr. Phillips' presentation?

28 Thank you very much, Mr. Phillips.

29 There is someone else who wishes to  
30 speak. Could you use the microphone?



1 THE PUBLIC: I have also been involved  
2 in drug use for quite a while and still am, actually, and  
3 it seems the motives of speed use that Mr. Phillips  
4 has given us don't really fill the bill. I have known  
5 a lot of people that tried speed and it really doesn't  
6 do anything for them. Like, if you are really well  
7 adjusted, speed doesn't give you anything except a rush  
8 and then it goes away. The type of person you are  
9 dealing with that is a speed freak is definitely a person  
10 that does things rather inadequately, in what he is doing;  
11 impotent; always hassled by his parents or by the law or  
12 something, and the speed high just kind of makes him  
13 forget all his trouble I still use speed occasionally.  
14 I used to use it in high dosage for a period of about  
15 two years. There are many motivations for the use of  
16 speed. I very rarely run into pill use in Canada. I  
17 am from Toronto and I can liken the Halifax speed scene  
18 to what was in Toronto two years ago when I started to  
19 use speed there.

20 DR. LEHMANN: Would it be justified to  
21 say the difference between oral use and intravenous  
22 use, shooting it or dropping it, is there the difference  
23 betwee having a rush and not having a rush?

24 THE PUBLIC: Pretty much so, yes. But  
25 I found the availability of amphetamine type pills is  
26 very low. And if you want speed for whatever your  
27 purposes, it pretty well has to be in injected form.

28 DR. LEHMANN: If you could swallow the  
29 stuff, then it would be exactly the same?

30 THE PUBLIC: Swallowing speed sometimes





1 gives you stomach cramps and gas, and it is a bit of a  
2 drag.

3 DR. LEHMANN: No. It is actually  
4 spasmolitic. It helps if you have stomach cramps. It  
5 just isn't being done.

6 THE PUBLIC: You ask a head some day and  
7 he could tell you that. I remember taking it by pill  
8 one day and remember throwing up for quite some time  
9 after. Speed can be used --- strictly as a stimulant  
10 and that's what I use it for now when I get around to  
11 use it, which is very rarely. I haven't used speed  
12 steadily for about nine months now.

13 DR. LEHMANN: If you use it as a  
14 stimulant, do you still shoot it?

15 THE PUBLIC: Definitely.

16 DR. LEHMANN: Have you ever tried  
17 dropping it?

18 THE PUBLIC: On several occasions, yes.

19 DR. LEHMANN: And you don't find it as  
20 effective as a stimulant?

21 THE PUBLIC: It is as effective as a  
22 stimulant but I like a rush too. The reason people use  
23 speed is because they do like it, it is a very enjoyable  
24 experience. It is also very damaging. I also had an  
25 experience in the speed clinic that Brian was mentioning.  
26 I rather think that the speed clinics attack the problem  
27 from the wrong angle. Rather than supporting the speed  
28 freak --- if you are using speed you have to be willing  
29 to pay the dues for your indiscretions, and the speed  
30 clinic, Digger House, is eliminating most of the dues,



1 having a hard time crashing and if you are down, they  
2 feed you. I believe to withdraw a person from speed, they  
3 have to more or less let him draw himself to more of a  
4 crisis and then treat him for the crisis. You can't  
5 confine a person against his will when he is sick enough  
6 not to want to do anything.

7 DR. LEHMANN: This is something found  
8 out quite frequently from speed freaks, that they want  
9 to stop using it but they are also quite convinced that  
10 they can't and nobody can stop them right then. But  
11 many of them say, "I will stop it. I am quite sure I  
12 will stop it. I don't know when. But when the day  
13 comes, perhaps <sup>tomorrow,</sup> perhaps in a year or two or three,  
14 I think I will just wait for it and then I will stop  
15 it". And a lot of them have. Now, what happens to them  
16 when they simple decide they have had enough and they  
17 don't need it anymore?

18 THE PUBLIC: In my case I woke up five  
19 days after being carried into the Toronto General  
20 Hospital with hepatitis, malnutrition, bronchitis, all  
21 at once, and had running sores on my body and I couldn't  
22 talk and couldn't eat and after about a month in there  
23 recovering from various ills, and hepatitis, I walked  
24 out of Toronto Hospital thoroughly convinced I wasn't  
25 going to hit up again, and I was back in four days,  
26 overdosed like, to the point I couldn't move. And they  
27 admitted me to a psychiatric ward there, and I was in  
28 the psychiatric ward approximately two months. I have  
29 been in the psychiatric ward perhaps a dozen times. The  
30 point is I found the speed use took me to the point, my



1 doctor told me it went to a point of going to the  
2 hospital and I couldn't survive the experience. I just  
3 didn't want to get back into speed use. I don't see  
4 anybody wanting to get into a situation, other than the  
5 fact they don't give a damn about their life. In the  
6 speed community you have characters running around with  
7 guns and knives quite willing to use them. In self  
8 defence you have to use one too. A person has to be  
9 bloody suicidal to get into speed use. And this is the  
10 type of person you are dealing with, if you are dealing  
11 with a speed freak. They are basically unhappy and  
12 they don't care whether they live or die, they just  
13 want to do speed.

14 DR. LEHMANN: Did you know all of that  
15 when you were taking it?

16 THE PUBLIC: No, I figured that out  
17 since. I figured that out from my own attitudes at  
18 the time. I was more or less one of your alienated  
19 youth. I kind of had a text book case. My parents  
20 were alcoholic and all that shit, and I just had never  
21 got along in school. My father kicked me out of the  
22 house when I was sixteen years old, and let me back in  
23 and kicked me back out when I was seventeen, and let me  
24 in again and kicked me out when I was seventeen and  
25 kicked me out again when I was eighteen, and I haven't  
26 been back since. I got into the drug community --- I  
27 suppose I started when I was twelve years old, I used  
28 to steal wine and beer and carry on. I figure in the  
29 last seven years I was pretty well stoned.

30 DR. LEHMANN: Would you have believed





1 everyone and would they have influenced you if they had  
2 told you what you have just told us now, how suicidal  
3 and crazy someone would have to be in order to get into  
4 the speed use? If someone had told you this when you  
5 were using it, what would have been your reaction?

6 THE PUBLIC: I most likely would have  
7 agreed with them. When I was using speed, I found  
8 coming down to be totally intolerable because I just  
9 wasn't very happy to begin with. I could do a hit and  
10 forget my problem for a while and when you come down,  
11 your problems lead to another hit. And that is what  
12 makes a speed freak. He crashes, wakes up and does a hit  
13 and doesn't stop until he passes out. Lots of people do  
14 a hit of speed on the weekend and they don't really see  
15 how it is harming them.

16 DR. LEHMANN: Have you any suggestion  
17 about what one might do in order to get some of these  
18 speed freaks out of it and get them to the occasional  
19 use, perhaps, as you are using it now?

20 THE PUBLIC: Well, what the person has  
21 to do, they are going to have to accept what they are  
22 and try and make some kind of a reasonable life for  
23 themselves. It is something that nobody can do for  
24 them. A speeder can't be put into a hospital and with-  
25 drawn and made healthy / then set out in his own circle  
26 of friends. He has to realize if he wants to stay off  
27 speed and make a decent life, he has to change his circle  
28 of friends and make other communications. And he has to  
29 do this all for himself and no one can do it for them.  
30 And that was my specific purpose for leaving Toronto.



1 I knew if I stayed in Toronto I would end up hanging  
2 around with the same people again, and doing the same  
3 sort of stuff. So I just left. I was in North Toronto  
4 for a while.

5 DR. LEHMANN: So the first advice for  
6 anyone that wants to get off it is to tell him to get  
7 away from where he is?

8 THE PUBLIC: Yes. To tell him to change  
9 his circle of friends at least, to get out of the drug  
10 community. I find that the speed community seems to  
11 have a rather inverted set of values. The person who  
12 is the all time speed freak and about to die is the  
13 person who cannot cool it. I also believe it takes  
14 some kind of education to repair his value system so  
15 that you don't value the person who is all mixed up as  
16 being a hero. Speed freaks have got to be made to  
17 realize that they are not the top of the social ladder  
18 as they believe they are. They are at the bottom. This  
19 way a person can gain a different perspective on what he  
20 is doing, and work his way out of speed use with the  
21 help of institutions and psychiatrists, which are very  
22 hard to come by.

23 MR. STEIN: What about the suggestion  
24 that was made earlier, that there have to be special  
25 clinics for speed users or else they would not feel that  
26 they would be --- I am not sure I could paraphrase you  
27 --- but part of it was that they felt themselves to be  
28 better than the elite --- I think you said.

29 MR. PHILLIPS: Probably.

30 MR. STEIN: Well you are suggesting that



1 that is not a very helpful quality to perpetuate, this  
2 elitism.

3 THE PUBLIC: It is my impression and  
4 opinion that it was more<sup>of a</sup> support for speed freaks,  
5 it was more supporting the habit than trying to diminish  
6 the habit and possibly complicating the habit by  
7 dependency on tranquillizers; whenever they were having  
8 a bad time they depended on tranquillizers. I suppose  
9 that you could use the tranquillizers, but if you are  
10 doing a long term withdrawal ---

11 MR. STEIN: You are objecting to the  
12 type of methods they use, but what do you think of that  
13 certain facility?

14 THE PUBLIC: A speed freak does not trust  
15 anyone except another speed freak, and just to get into  
16 the place he would have to be a speed freak. Nobody  
17 really likes speed freaks. Speed freaks have a habit  
18 of stealing everything in sight. And speed is a very  
19 expensive habit. To get up, you need \$75.00 worth of  
20 speed, and they take a mutual dislike ---

21 THE CHAIRMAN: How much does it cost on  
22 the average, daily to support a chronic speed freak's  
23 habit?

24 THE PUBLIC: At street prices, the amount  
25 that I was using to feed my habit would probably cost  
26 around \$70.00.

27 DR. LEHMANN: How much?

28 THE PUBLIC: \$70.00 a day. I was buying  
29 approximately two weight ounces of speed a day, and  
30 doing half of it.





1 THE CHAIRMAN: What were you doing with  
2 the other half?

3 THE PUBLIC: I was selling it to support  
4 my habit. There was no way I could support the habit.

5 DR. LEHMANN: So then how does it work  
6 out now? You really used \$35.00 worth?

7 THE PUBLIC: I suppose, but to go out  
8 on the street and buy half a weight ounce would cost  
9 you \$60.00.

10 DR. LEHMANN: How did you put it in  
11 weights? Half a weight ounce --- 30 grams?

12 THE PUBLIC: They were selling about  
13 28.5 grams. I had a set of scales which I used.

14 DR. LEHMANN: A weight ounce is 30 grams.  
15 And half of this you would use and half of it you would  
16 sell?

17 THE PUBLIC: I would use two ounces.

18 DR. LEHMANN: Two ounces a day, that is  
19 60 grams?

20 THE PUBLIC: And I was using half a  
21 weight ounce myself.

22 DR. LEHMANN: Fourteen to fifteen grams  
23 a day.

24 THE CHAIRMAN: I just want to confirm,  
25 14 to 15 grams a day?

26 DR. LEHMANN: You used it every two hours  
27 you said?

28 THE PUBLIC: Approximately, until I  
29 could not take any more.

30 THE CHAIRMAN: You would shoot each time



1 about 2,000 milligrams.

2 I want to make sure I have that price  
3 straight. \$70.00 for how much, again?

4 THE PUBLIC: It would be about half an  
5 ounce.

6 THE CHAIRMAN: \$70.00 for half an ounce?

7 THE PUBLIC: Yes, I suppose. I was  
8 paying about \$85.00 an ounce --- buying it by the ounce.  
9 In Halifax, they sell you a quantity which they call a  
10 spoon for \$25.00 and it amounts to a couple of grams.  
11 The most economical way --- I have not seen speed  
12 used here to the large proportion it is used in Toronto.

13 DR. LEHMANN: Are there many people now,  
14 compared to in Toronto, that use speed to the extent which  
15 you used it, now?

16 THE PUBLIC: Certainly where individuals  
17 like Murray Speed Freak, which you have probably heard  
18 of, he is a legend among speed users everywhere.  
19 I have seen him on occasion hit up seven grams in one  
20 hit.

21 DR. LEHMANN: That is rather exceptional  
22 isn't it?

23 THE PUBLIC: It is rather exceptional.

24 DR. LEHMANN: It costs as much, then, as  
25 heroin?

26 THE PUBLIC: It can cost as much as  
27 heroin, but then it is a matter of tolerance. You could  
28 develop a tolerance to speed; where it could kill one  
29 person, you might not even feel it. I still have quite  
30 a high tolerance after nine months of non-use.



1 DR. LEHMANN: How do you know that?

2 THE PUBLIC: Because I have done a few  
3 hits recently.

4 DR. LEHMANN: But you are taking a chance  
5 aren't you, because a lot of heroin users have not  
6 realized that their tolerance had dropped when they  
7 hadn't taken it for a month or two and they would kill  
8 themselves, whereas a month or two later it would not  
9 have done anything to them.

10 THE PUBLIC: Yes, it is taking a chance.

11 DR. LEHMANN: So you are taking a chance,  
12 but you feel it is justified, or anyway you have not  
13 heard of anyone who has suffered grave consequences of  
14 losing his tolerance and then going on the assumption  
15 that he is still tolerant?

16 THE PUBLIC: I have found that most  
17 people are aware that their tolerance is going to drop  
18 and they are going to experiment with small hits.

19 DR. LEHMANN: So they are experimenting  
20 to find out first?

21 THE PUBLIC: Yes, to find out how much  
22 they can take. Speed freaks are not altogether stupid.

23 THE CHAIRMAN: Thank you very much.

24 I would like to call now on Mr. Allister  
25 Watt of the Halifax Youth Communication Society.

26 Thank you Mr. Phillips.

27 Mr. Watt?

28 MR. WATT: Mr. Chairman, Commissioners,  
29 it has been about eight months since I appeared before  
30





1 you the last time. The last time I was --- as I am now,  
2 in one of three different roles, really. One is  
3 Executive Director of the Halifax Youth Communication  
4 Society from which you have already heard. I am not  
5 really appearing on behalf of that society now, because  
6 they have pretty well made their presentation. The  
7 other is with the Nova Scotia Youth Agency which is of  
8 the Provincial Government. I am not appearing as the  
9 official delegate, but I am on their staff and my field  
10 there is combined between the whole area of drugs and  
11 transient youth across the province of Nova Scotia.  
12 The third area, the strange role I have in Halifax  
13 is being the first street worker in Halifax who was  
14 hired by the Youth Agency to set up the Digger House  
15 two years ago. And so, in that capacity, I am supposed  
16 to be professionally around the street longer than any-  
17 body else. Now, you are probably aware that this type  
18 of innovative service operation, the kind of, what you  
19 might call in street terminology, changes that you go  
20 through working there, you simply cannot function at  
21 street level over that length of time efficiently. So,  
22 really, I have been working in the street only about  
23 a year. I have been doing as much money hustling and  
24 spreading the word.

25 I wanted to sort of try and give you  
26 some sort of view of what has happened since you were  
27 here last and since your report has come out, because  
28 I gather that this is one of the things you wanted to  
29 hear about; perhaps, I might be able to shed some light  
30 on it. Since January, I have, personally, from the Youth  
Agency in official capacity, visited seventeen towns in



1 Nova Scotia at their request to give drug education in  
2 their public schools, in their communities, workshops  
3 and so on. I stress that every one of these was at  
4 the request of the town. Every single one of them was  
5 up tight about drugs coming into rural Nova Scotia, and  
6 very few of them had even enough information to be able  
7 to handle even an acid freak. This is improving fairly  
8 rapidly. There are segments of the province where  
9 various towns are trying to pool their resources, but  
10 generally speaking they are all running across the  
11 common frustration of, first, inability to grasp what  
12 might really possibly be done in terms of education  
13 or preventative programmes or even crisis and rehab.  
14 The cases, the types of problems in Halifax are pretty  
15 typical of the types of problems in rural Nova Scotia.  
16 If we have the money and facilities to service problems,  
17 to get kids to recognize they have a problem, to trust  
18 you, there is still nothing you can do beyond that.  
19 I checked out yesterday with Halifax, for example. I  
20 called seventeen different agencies, government bodies,  
21 municipal governments to see how many would even be here,  
22 and the number, I think it was three of four, replied  
23 that they had some sort of interest to be here, let  
24 alone make a presentation. I know that is not an  
25 accurate estimation of the verbal concern we have been  
26 getting over the last year and a half, but it gives some  
27 indication of the type of frustration that we have been  
28 trying to deal with.

29 On the local level, things have improved  
30 immensely in terms of community awareness. Now, City Hall



1 is becoming much more involved. Private centres are  
2 becoming much more involved. At the provincial level,  
3 it is very hard to say, because of our political  
4 situation with the last election. I simply can't speak  
5 for the Provincial Government. The Youth Agency has  
6 been pretty consistent with its stand all along the  
7 way and we have come to the conclusion, and this can be  
8 taken as an official statement, that what is badly  
9 needed is for the Provincial Government to make a  
10 commitment to pool together resources at the municipal,  
11 private, <sup>and</sup> federal levels to try and get something clearly  
12 established and done in the province, because one of  
13 the major problems with this type of work, as you know,  
14 is the very scattered areas of funding and so on. This  
15 is happening here where City Hall is beginning to pool  
16 together people, but on the provincial level I think the  
17 role belongs to the Provincial Government, and the youth  
18 are starting to initiate this. We have had it in the  
19 books for some time ---

20 PROFESSOR BERTRAND: I am sorry, in your  
21 official statement you said that the Provincial Government  
22 should make a commitment to pool together resources at  
23 all levels toward what end precisely --- education,  
24 treatment, what?

25 MR. WATT: Well, really, all the things  
26 that you hear of. For instance, provincial drug education.  
27 There is a Youth Agency, there is Department of Health,  
28 Department of Education, but there is no provincial  
29 drug policy, no provincial drug committee. Obviously  
30 the province has to get itself together and say what are





1 we going to do, how are we going to do it, and who are  
2 we going to use. That has not been done yet. There have  
3 been two attempts at this across the province. One  
4 was, in effect, a provincial drug committee without an  
5 official --- without real powers, which was called by  
6 the Minister of Education some time ago. That voluntarily  
7 closed up when the Nova Scotia task force on the non-  
8 medical use of drugs made its presentation to you eight  
9 months ago here, and <sup>said</sup> / they were going to coordinate  
10 that type of programme for the province, largely on  
11 education --- that includes the resource people to  
12 speak --- crisis centres, the other types of approaches  
13 that can be made. Simple evidence is so far that what  
14 has been done by the Nova Scotia task force is that  
15 they simply could not do it. Nothing much happened.  
16 So now it has become clear that if anything is going to  
17 be done, it has to be done with a very clear and  
18 deliberate official policy. All too often the people  
19 involved have been working on a part time basis.

20 MR. STEIN: I was going to ask you -- are  
21 they still in existence or have they given up, in/that task<sup>performing</sup>?

22 MR. WATT: I haven't heard much from  
23 them in the last few months or I haven't seen any  
24 evidence they have done anything apart from having  
25 meetings.

26 MR. STEIN: To your knowledge, they  
27 would still be meeting?

28 MR. WATT: As far as I know. I unfor-  
29 tunately was not able to contact the chairman of that  
30 task force yesterday, so I don't know where they are.



1 I understand they are not going to make a presentation  
2 through,  
3 to the Commission this time / so I really don't know  
4 what they are doing. In effect, the frustration from  
5 the point of view of the person who is using or abusing  
6 drugs is that, federally, apart from the changes in the  
7 marijuana law to simple possession being indictable  
8 offence or summary conviction, with regard to speed  
9 analysis, with regard to deliberate attempts to give  
10 out funding for various types of programmes, they are  
11 there  
12 literally on the street level / has been no change.  
13 The frustration of the workers in this field has been  
14 regardless of what has been said by the LeDain Commission  
15 or what the report is, the Federal Government has not  
16 made up its mind yet and it has been eight months,  
17 and the frustration, of course you realize when you  
18 are working at the street level, you are seeing kids  
19 being badly damaged all the time. In Nova Scotia we  
20 still do not have decent facilities or rehab facilities  
21 for adolescents. They have facilities at the Nova  
22 Scotia Mental Hospital, but the two alternatives is the  
23 emergency set up like the V.G. centre or mental  
24 hospitals, there is no in between. Now that is a huge  
25 gap and we have been saying that for a year and a  
26 half to two years. The problem is whoever is going  
27 to pour that together and say, "Okay, let's fill that  
28 gap", is going to have to do it on an official level,  
29 and that is why we have come with the Youth Agency  
30 and come to people and said, "Either do it or don't do  
it, but let us have your position one way or the other",  
because we have had a lot of frustration with people



1 saying, "Yes, we are going to do something", and nothing  
2 happens, which sets us back further.

3 I am not sure what you have been finding  
4 in other areas in the country, but I am sure this song  
5 of frustration is probably a pretty familiar sound to  
6 you. I think probably Halifax is in a much better  
7 position now than it was eight months ago. Certainly  
8 there are much more professional people that are aware  
9 of it. As I said, the private sector is very much more  
10 aware.

11 MR. STEIN: Perhaps you wouldn't know,  
12 but do you have any impression about the present  
13 policies being followed in a general sense in the  
14 courts in Nova Scotia on drug possession?

15 MR. WATT: Generally speaking, it seems  
16 to be following the pattern --- I am not sure exactly,  
17 but generally speaking the penalties for simple possession  
18 of marijuana without <sup>major</sup> extenuating circumstances have  
19 been substantially lower than they were two or three  
20 years ago. In other words, they have got down to a level  
21 of comparably what Toronto was doing a couple of years  
22 ago.

23 MR. STEIN: Which would be what?

24 MR. WATT: \$250.00, \$150.00 and suspended  
25 sentence for simple possession. It is very hard to tell  
26 because our local newspapers, when they print who has  
27 been arrested, on what charge, first of all, don't  
28 print much about the circumstances of the case. I have  
29 run across that trap before and I'm not going to follow  
30 it this time. Trying to judge an individual case without





1 reading the court record because there are so many  
2 extenuating circumstances. It's like the fellow who  
3 said he got two years for possession, and the possession  
4 was 92 pounds of hash. Well, that's a little tricky.

5 MR. STEIN: You say you have aged since  
6 we saw you last?

7 MR. WATT: Yes. It has been a long  
8 year.

9 I read very carefully your comments on  
10 the innovative services and that is specifically why I  
11 mentioned that even despite the fact of those recommenda-  
12 tions which I wholeheartedly agree with for obvious  
13 reasons, but it really hasn't helped us much, because  
14 there has been no change at a federal level apart from  
15 what we were already involved with when I say you last.

16 MR. STEIN: What is it, exactly, you are  
17 getting from Health and Welfare at the moment?

18 MR. WATT: We are under a three year  
19 demonstration project. This means our annual grant ---  
20 we have an annual grant for three years subject to  
21 review at the end of each year, and subject to various  
22 accounting procedures and reports and so on.

23 MR. STEIN: To the amount of what?

24 MR. WATT: This year, which was a ten  
25 month year, starting the first of June through to the  
26 end of March, 1971, was \$28,000.00. Now basically, we  
27 are running about a \$40,000.00 a year operation, pretty  
28 well.. The plans of --- here I am talking about Head-  
29 quarters you see. The kind of problems we ran across  
30 made things even more difficult, that is, Headquarters is



1 not just a drug oriented operation as Mr. Phillips pointed  
2 out. The statistics on the number of kids we handle,  
3 just straight transient youth with feeding and housing  
4 this summer was more than three times that of last  
5 summer. I don't have them here in front of me, Mr.  
6 Phillips has them, that will be tabled later, but one  
7 of the problems, of course, as with any of these, the  
8 projection of cost figures where your clientele varies  
9 widely according to whims that are pretty unpredictable.  
10 We didn't know whether we were going to have twice as  
11 many transients or three times as many, or five times  
12 as many this summer. Much of the energy we had to  
13 expend this summer/<sup>or that</sup>was expended this summer, at the  
14 house, was simply hustling food, because we literally  
15 could not get any money from municipal, provincial,  
16 or federal governments, or a lot from private sources  
17 to feed fifty meals a day for a period of three months.  
18 So we finally got money from the Century Estate  
19 Department near the end of August, at which time we  
20 had served close to 4,000 meals. So that kind of energy  
21 scrounging saps the energy of actually doing something  
22 a little more productive than running around hustling  
23 cases of vegetables.

24 MR. STEIN: Was there a Federal Government  
25 hostel in Halifax this summer?

26 MR. WATT: No, there wasn't.

27 MR. STEIN: Nothing opened up in all of  
28 Nova Scotia? The thing I am referring to is what happened  
29 under the Secretarial States Department in other cities  
30 where the youth would use the army facilities.



1 MR. WATT: No. I would gather the main  
2 reason for that would be of course that we were  
3 specifically funded partly as a transient youth operation.  
4 The Headquarters project is partly a transient youth  
5 project. That is part of its functions.

6 MR. STEIN: That may be, but in Vancouver  
7 where Cool Aid is getting the same kind of grant, it  
8 is a separate matter. It is also a very well publicized  
9 facility in Vancouver, this summer for this purpose,  
10 and there was no conflict of interests, apparently.

11 MR. WATT: We did get a grant from that  
12 organization that funded the armories in other cities.  
13 That was where we got a total of \$5,250.00 from the  
14 Department of the Secretary of State. <sup>But,</sup> /that was to be  
15 used for salaries at the Y.M.C.A. which we were paying.  
16 The society had agreed to pay us as part of a transient  
17 youth operation.

18 MR. STEIN: Did you have this last  
19 summer? I remember you telling us you were worried  
20 you did have, but did you have a large "transient youth"  
21 population in Halifax this summer, so much so you were  
22 really in desperate need for places to sleep people?

23 MR. WATT: Certainly in August we were  
24 badly over crowded with our facilities at the Y.M.C.A.  
25 We were averaging pretty close to 75 people a day. I  
26 don't have the statistics in front of me. In August,  
27 we had 995 different people, and I remember that very  
28 clearly. That was almost twice as many as we had in  
29 July of last year. We had 519 in July and August of  
30 last year. And it was escalating still in September.





1 We don't have the statistics for September but these will  
2 be filed in due course. But the thing is expanding on  
3 a geonetric progression.

4 DR. LEHMANN: These are transients or  
5 drug users?

6 MR. WATT: These are transients.

7 DR. LEHMANN: Why are there twice as  
8 many transients this year as there were last year?

9 MR. WATT: I'm not sure. That is the  
10 feedback I get across the country too, that there are  
11 more. It just seems to be part of the snowball that  
12 started last ---

13 THE CHAIRMAN: There was more student  
14 unemployment this year.

15 MR. WATT: Yes. Also we had a fair  
16 number of Americans which I suspect might have to do  
17 with what is going on in the United States, because  
18 many of them felt they weren't particularly interested  
19 in going back right away. That is hard to say. That  
20 is projection on my part.

21 I didn't bring a written brief this  
22 time because I thought you might have, or I might be  
23 able to much better feedback to your questions, and  
24 if you had no questions, that is fine too.

25 DR. LEHMANN: When we say you last year  
26 or early this year, you were telling us that the speed  
27 scene was just developing here. It was rather in  
28 infancy. But now it seems to be fully grown.

29 MR. WATT: If I remember, I said  
30 last January that speed really started to come in in



1 September of last year, and it was percolating quietly  
2 over the winter. So it was just around January, it was  
3 just beginning to show at the edges. Now the patterns  
4 of speed use have extended out well into --- as I  
5 expected it probably would, and I think I expressed  
6 the fear at that time. Also the dynamics of the dis-  
7 tribution pattern has changed quite a bit too. It is  
8 no longer a matter of experimentation. Originally, in  
9 September, what was brought in was brought in for money  
10 by non-speeders. Now the speed community pretty well  
11 supplies its own. There are other dynamics to that  
12 which I don't care to go into right here.

13 THE CHAIRMAN: How do they supply their  
14 own?

15 MR. WATT: In effect, that now, as far as  
16 I can see, it is not outside people selling speed to  
17 speeders, it is speeders going and getting speed for  
18 speeders and themselves.

19 THE CHAIRMAN: Where are they getting  
20 it?

21 MR. WATT: That is a good question. I  
22 would rather go into this privately, because the things  
23 involved are pretty tricky.

24 THE CHAIRMAN: Would you give us an  
25 opportunity to get those figures?

26 MR. WATT: Yes.

27 THE CHAIRMAN: Any other questions or  
28 observations?

29 Would you like to use the microphone?

30 THE PUBLIC: I would like to ask why the



1 law couldn't be changed so that judges sentencing young  
2 people on drug charges, couldn't know more about drugs  
3 instead of just looking at them as evil people, and as  
4 you know, older people know not much about drugs, and so  
5 they wouldn't know the difference about one marijuana  
6 cigarette or a pound of heroin. It's obviously the  
7 same to them.

8 THE CHAIRMAN: Could you speak closer  
9 to the microphone please?

10 THE PUBLIC: I am wondering what will  
11 happen to these children that have been put in prison  
12 for drug charges for long terms and then we have cases  
13 of adults, married people setting up a place to sell  
14 drugs in a university town and they receive a very,  
15 very light sentence. Are we not going to end up with  
16 an awful lot of bitter young people? I feel that a lot  
17 of them are going to join groups like the FLQ because  
18 they are going to hate society so much for what society  
19 has done to them. I know, because I have a son in  
20 prison for five years, and he cried in court the day  
21 he was sentenced, and screamed to me; "Mom, tell them,  
22 I've never done anything wrong in my life, I'm not a  
23 criminal, I have never stole", and the prison padre  
24 tells me that he and others like him, they are in prison,  
25 they don't know what they've done wrong, because really  
26 they are not criminals and as such they haven't done  
27 anything truly wrong. He has been there since last  
28 February and he has been in a shock, and now he is  
29 coming out of the shock, and is turning against the  
30 whole world. And I presume that there are hundreds and





1 thousands like him across Canada.

2 (Applause)

3 THE CHAIRMAN: Anyone else?

4 If not, thank you, Mr. Watt, and we will  
5 further contact, I take it.

6 I call now on the representatives of  
7 the Beta Hi-Y of Halifax, Mr. Fred McMahon and Mr.  
8 Dennis Holland.

9 MR. McMAHON: We are obviously not  
10 experts in this area, and our report that we present to  
11 you is going to have many weaknesses. However, I believe  
12 and members of our committee believe that in passing  
13 out a poll to our high school people, and having members  
14 of the same age group interpret the results, we could  
15 help the members of your Commission to better understand  
16 the feelings of this age group. You might also notice  
17 by looking at the poll that we have dealt only with  
18 cannabis and LSD because, of those people polled, these  
19 were the only drugs used, and so we felt we should leave  
20 the other drugs which these people were not using, out.  
21 However: the introduction. The Commission of Inquiry  
22 into the Non-Medical Use of Drugs has received many  
23 prepared reports from medical groups, sociological groups,  
24 college groups and other adult interest groups. However,  
25 to our knowledge, it has received very few prepared  
26 reports from high school age groups. This age group  
27 probably is affected most, after college students, by  
28 whatever recommendations the Commission makes and by  
29 the laws passed on this issue by the Parliament of  
30 Canada.



1                   Therefore, we believe that a report by  
2 high school students concerning the views of this age  
3 group, and their reactions to the interim report of  
4 the Commission would be beneficial to the Commission's  
5 present phase of inquiry. To achieve this means of  
6 expressing as best we could the views of this age group,  
7 we felt it necessary to conduct a poll. Because none  
8 of us are experts in this field, we do not feel that  
9 our poll is as accurate as it could be, but we do  
10 believe that it is fairly reliable.

11                   To compile a study from this age group  
12 we felt it necessary for high school students to draft  
13 the report and interpret the results of the poll, as  
14 they would be in the best position to understand the  
15 feelings of their peers.

16                   Two polls were taken. The first poll  
17 was taken in a "Y" dance which attracted more non-Y  
18 than actual members. We established a base to which  
19 people could come and fill out our questionnaire;  
20 however, restricting those filling out the form to  
21 non-Hi-Y members. We suspect that because of the  
22 conditions present we tended to attract those more  
23 acquainted with the drug scene.

24                   We took the second poll by passing out  
25 our questionnaire to other Hi-Y clubs while their  
26 meetings were in progress. The cooperation we received  
27 on this aspect of our project was very good and we  
28 believe our results to be fairly accurate and represen-  
29 tative.

30                   It is generally believed that the



1 people in the Hi-Y clubs themselves come, for the most  
2 part, from middle and upper class segments of society,  
3 while the reverse appears true of those polled at the  
4 dance. Though this is just an assumption, we shall  
5 treat it as fact in the report simply for brevity, so  
6 that we will not have to state that it is only an  
7 assumption each time we feel it necessary to differentiate  
8 between the two groups. Furthermore for simplicity we  
9 shall use the term "upper-middle and upper class" and  
10 we shall use the term "lower class" when what is meant  
11 is "lower-middle and middle class".

12 On our questionnaire we have eleven  
13 questions and we shall simply refer to them by their  
14 numbers. We also have three sets of Questions: A,  
15 B, and C. We shall in our report refer to the first  
16 set as A,B,C, and second set as A-2, B-2, C-2 and so on.

17 As will be noted from the first question,  
18 many of those polled thought that the LeDain Commission  
19 educated the Canadian public to an extent. However,  
20 the majority felt that the Commission did not educate  
21 the Canadian public much, if at all. These results can  
22 be taken in two ways. One interpretation might be that  
23 those polled did not believe that the youth segment of  
24 society was educated by the LeDain Commission. In our  
25 opinion, this could be caused partly by the fact that  
26 the interim report of the Commission is too expensive to  
27 buy and for many, too long to read.

28 The other interpretation that we feel is  
29 possible, might be that those polled did not believe that  
30 the adult segment of society was educated by the LeDain





1 Commission. Because of the constant barrage of infor-  
2 mation on the issue of these drugs we feel that the adults  
3 in our society tended to close their ears and minds to  
4 any further discussion on this issue. Consequently,  
5 they paid little or no attention to the Commission's  
6 hearings and interim report.

7 The results of question 2 are obvious,  
8 and we feel leave no room for interpretation. The vast  
9 majority of those of high school age think marijuana  
10 should be legalized and many feel very strongly this way.  
11 It is significant to note the extremely small number  
12 who do not think marijuana should be legalized. Obviously  
13 the youth polls stand together on this issue.

14 Pertaining to question 3 on our survey,  
15 the results indicate that the majority of the young  
16 people feel that the recommendations of the LeDain  
17 Commission are not adequate. The results indicate to us  
18 that the majority of those polled are not satisfied with  
19 those recommendations because they do not provide for  
20 complete legalization of the possession of cannabis.  
21 During our poll taking, many of those polled orally  
22 expressed their belief that the penalties pertaining to  
23 the use of LSD should be lightened and a clear distinc-  
24 tion be made between the two hallucinogens. It seems to  
25 be widely felt that the marijuana user should not suffer  
26 as heavy penalties as the LSD user.

27 It is obvious from the results of  
28 questions 2 and 4 that more people believe cannabis should  
29 be legalized than those who have taken it. However, this  
30 difference can be attributed to question A-1. When those



1 who are willing to take marijuana are added on to those  
2 who have already taken it the total comes extremely  
3 close to the number who want it legalized.

4           Concerning the results of question C-1,  
5 it seems to be apparent that those polled who we believe  
6 to be from upper class income families (Hi-Y) do not  
7 appear to be affected in their use of the drug by the  
8 legal status of marijuana. However, it does seem  
9 apparent that for the lower income groups (non Hi-Y)  
10 the question of it being legal or not does affect their  
11 usage to an extent, in that a few more would take the  
12 drug if it were to be legalized, than are now using it  
13 or planning to take it.

14           The slight relative reluctance of the  
15 latter group to indulge in marijuana unless it is  
16 legalized, we feel, can be attributed to the fact that  
17 because of the policies of our police department,  
18 lower class youth have more direct contact with the law  
19 than upper class youth, i.e., police patrol lower class  
20 areas more frequently than upper class areas.

21           However, from the results of question  
22 C-1, it appears that neither group would be seriously  
23 affected in their use of marijuana if simple possession  
24 were made a non-indictable offence.

25           From the answers received to question  
26 A-2 it appears that many young people are afraid of  
27 being caught by the authorities and/or their parents.  
28 However this does not seem to affect the extent of their  
29 usage, as shown by the answers to questions A-1, B-1  
30 and C-1. It is significant to note those from lower



1 income backgrounds (non Hi-Y) appear to be more afraid  
2 of being caught than those from upper income backgrounds  
3 (Hi-Y). Our conclusions in this matter are also supported  
4 by the answers to questions A-1, B-1 and C-1.

5 THE CHAIRMAN: Excuse me, is there a  
6 distinction of non Hi-Y income and Hi-Y?

7 MR. McMAHON: Basically, that was our  
8 assumption. This is hard to back up in fact, but it  
9 is basically thought among the "Y" members that those  
10 who are in the "Y" do tend to come from upper middle  
11 and upper class backgrounds, upper income backgrounds,  
12 while those we met at the dance would generally come  
13 from lower income backgrounds and this is<sup>a</sup>/generally  
14 accepted fact but can't really be backed up.

15 From B-2, we can say that more people  
16 are afraid of the police than their parents. We shall  
17 attempt to explain the individual choices in this. Those  
18 who are more afraid of their parents are probably worried  
19 about the short term effects, i.e., causing a bad  
20 hassle with their parents and possibly getting kicked  
21 out of the house, while those who are afraid of the  
22 police are probably most worried about the long terms  
23 effects, e.g. a mark on their record. Fines and jail  
24 sentences are not commonly used on a first offence,  
25 though a convicted defendant ---

26 THE CHAIRMAN: Excuse me, I just wanted  
27 to get the correction you made about the long term  
28 effects, what do you substitute there? A mark on one's  
29 record, right. And the next sentence. Fines and jail  
30 sentences are not commonly used.





1 MR. McMAHON: ...though a convicted  
2 defendant always gets a criminal mark on his or her  
3 record -- obviously a long term problem. Our assumptions  
4 in this matter are backed up by the answers to question  
5 C-2.

6 Another factor in the fear of parental  
7 knowledge of drug use may be consideration, on the part  
8 of the user, of the effect this might have on the  
9 parents' feelings, and social and moral standing.

10 Those who have stricter parents with  
11 less liberal views on the legalization of marijuana  
12 would have a greater tendency to fear their parents.

13 It will seem, from the answers received  
14 to question C-2, that the majority of both groups  
15 polled, fear most a mark on their records. It is  
16 significant to note that those from lower income groups  
17 (non Hi-Y) are statistically more afraid of receiving  
18 a fine or jail sentence than those from upper income  
19 groups (Hi-Y). The explanation for the former group's  
20 greater fear of a fine is obviously less access to  
21 money and less willingness on the part of parents to  
22 pay large fines.

23 In question 7 the largest number of  
24 people in both groups polled answered that they trust  
25 the people from whom they buy drugs to an extent. It  
26 should be noted though, that the majority of the  
27 remainder from upper income families answered either (a)  
28 "completely" or (c) "not much", with only one person  
29 answering (d) "not at all". However, those from  
30 lower-income families spread the rest of their answers



1 almost equally among (a) "completely", (c) "not much",  
2 and (d) "not at all". Furthermore, the difference  
3 among those who answered (b) "to an extent", and those  
4 who checked (a) or (c) or (d) was not as pronounced  
5 in the lower income groups.

6 We feel that the difference in the way  
7 the two groups answered can be explained easily. Those  
8 of upper income class backgrounds, belonging to Hi-Y,  
9 mainly deal with a small, fairly reliable clique of  
10 pushers, while those from the lower income groups, not  
11 in the Y, would have to deal with a wide variety of  
12 whose who...

13 (Following page is 175)  
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1 would have different levels of reliability.

2 It is obvious from the answers to questions  
3 5 and 6 that there is a clear distinction in young  
4 people's minds between marijuana and LSD. The vast  
5 majority of young people do not want LSD legalized and  
6 most have not taken the drug. It should however be noted  
7 that of those polled, more had taken LSD than want it  
8 legalized. We can further conclude from the answers to  
9 questions A-3, B-3, and C-3 that the legalization of LSD  
10 or the removal of simple possession of LSD from the  
11 Criminal Code would make absolutely no significant  
12 difference in the amount of LSD usage, among those polled.

13 We intended to use the results from  
14 question 8 to break down those polled into four separate  
15 groups based on the amount of involvement. Unfortunately  
16 we did not have time to do this. Thus the results to  
17 this question are irrelevant.

18 We can see from the results of question  
19 9 that those who saw some revision of the laws concerning  
20 marijuana and LSD would not blame any failure to do this  
21 on the Trudeau government. Instead they would find  
22 fault with "outside pressure". It appears to us that  
23 any failure of the Trudeau government to lighten or  
24 eliminate the penalties for the simple possession of  
25 marijuana and LSD will not cause any great loss of  
26 support from the youth segment of Canadian society.

27 A surprisingly large minority of both  
28 groups polled felt that no other federal law had as much  
29 direct effect on them as the laws concerning cannabis and  
30 LSD. The vast majority of those polled feel that



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1 marijuana should be legalized and many feel that no  
2 present federal law has as much direct effect on them as  
3 the laws concerning marijuana and LSD. Something must  
4 be done soon on this issue, otherwise these people are  
5 bound to be upset at "non-enlightened outside pressure".

6 The answers to question 11 on how  
7 interested in this issue youth considers itself is not  
8 too relevant, unless compared to how interested they  
9 consider themselves in other issues. Nonetheless, we  
10 believe that they are probably more interested in this  
11 than any other national issue.

12 We believe that if the LeDain Commission  
13 wants to reach as many young people as it can with its  
14 final report, it might be wise for the Commission to  
15 publish a condensed form of their report which would be  
16 cheaper to buy and shorter to read and they should produce  
17 a film on the hearings with visual samplings on the  
18 findings. We realize that the production of a film  
19 could be called "gimicky". However, if it is well done  
20 it will attract and hold the attention of many people  
21 and educate them at the same time. We also believe that  
22 the film and condensed form of the report, if they are  
23 created, should be circulated to schools across the land.

24 We believe that marijuana should be  
25 legalized and be placed under the exclusive control of a  
26 Crown Corporation. The reasons are as follows:-

27 (1) As the law exists now many people simply ignore it;  
28 of course this makes a mockery of the law.

29 (2) We also note that according to the results of our  
30 poll there would be no significant difference in the



1 amount of usage of marijuana.

2 (3) There is no medical proof that cannabis does mental  
3 or physical harm, that we know of.

4 (4) Many young people are getting polluted marijuana  
5 which can, depending on the type of pollution, do both  
6 physical and mental damage.

7 (5) As the law stands now many young people who are in  
8 no way criminals and have bright futures to look forward  
9 to, have their lives ruined by getting a criminal record  
10 for doing something that is becoming increasingly  
11 socially acceptable.

12 Furthermore, a side benefit would be  
13 the increasing of government revenues through the sale  
14 of marijuana and the lessening of some underworld profits.

15 We also believe that the penalties for the  
16 simple possession of LSD should be lightened and that  
17 it should be made a non-indictable offence, simply because  
18 we believe present penalties are too harsh.

19 We strongly support the LeDain Commission's  
20 recommendations regarding government sponsored and  
21 conducted researches into the mental and physiological  
22 effects of cannabis and other hallucinogenic chemicals.

23 We finally recommend government coordina-  
24 tion of help centres for people with drug problems in all  
25 major centres across Canada.

26 In many ways this is a trial. Your  
27 report in the last half of this issue will be your  
28 judgment as adults in a growing segment of the youth  
29 oriented society, and in turn your judgment will affect  
30 in some ways how this new society judges you.



1 MR. STEIN: I just wanted to know if  
2 you had indicated at the beginning the number of people  
3 who would have filled in the questionnaire, approximately.

4 MR. McMAHON: You each, I believe, have  
5 a copy of the questionnaire, and under each question in  
6 a box you will find a figure filled in and this will be  
7 the number of people who answered that particular question.

8 MR. STEIN: Thank you.

9 MR. CAMPBELL: Mine has some of the data  
10 in blue ballpoint and some in pencil. Can you tell me  
11 what the difference is?

12 MR. McMAHON: The blue ballpoint to the  
13 left would be those who are from non Hi-Y and the pencil  
14 to the right would be those who are from Hi-Y

15 DR. LEHMANN: More specifically to your  
16 recommendations, or the reasons given for your  
17 recommendation that marijuana should be legalized, number  
18 4, "Many young people are getting polluted marijuana  
19 which can, depending on the type of pollution, do both  
20 physical and mental damage." That is a bit difficult  
21 to conceive. Have you heard of such cases? It is  
22 cabbage leaves, and parsnip and so<sup>on</sup>/ which certainly  
23 doesn't deliver the goods, but it doesn't do any harm.  
24 Have you heard of any cases?

25 MR. McMAHON: As we have stated, we are  
26 not medical experts, but from talking to people and our  
27 own personal observations, we have heard of possible  
28 rare cases, but we do know of no cases where harmful  
29 substances have been put into marijuana, and I couldn't  
30 give you a specific case.





1 DR. LEHMANN: There has been a lot of  
2 rumour about heroin being put in; that for a long time  
3 was not substantiated and I think then there came some  
4 substantiation from somewhere from the west coast in the  
5 United States, though, in general, one can use the same  
6 argument just the opposite way and say, if it isn't  
7 legalized, then there will be cabbage leaves and all  
8 other stuff sold as marijuana and actually that may be  
9 less harmful than marijuana. But there is very little  
10 medical evidence that smoking something that isn't  
11 marijuana really is as harmful as for instance, shooting  
12 something that isn't speed or heroin, and so on.

13 MR. McMAHON: That is probably very true.  
14 By the way, we have heard of such things as you said,  
15 heroin being put in marijuana and possibly number 4,  
16 the polluted drugs, would only be a very small percentage  
17 of actually happening. But I am sure in many cases it  
18 does, because whether it is cabbage leaves or not, it  
19 is quite often something else and you can't buy pure  
20 drugs anywhere in Canada that I know of.

21 DR. LEHMANN: Whatever you smoke, it is  
22 probably no more harmful or perhaps less than marijuana  
23 would be. But it isn't the money's worth they are asking  
24 for, that is quite true. From the economic point of view  
25 they are being cheated. From the health point of view  
26 it is a different story.

27 MR. McMAHON: Thank you.

28 MR. STEIN: What is your impression, and  
29 this is not directing the question specifically to your  
30 report but to the conversation that preceded your appearance.



1 What impressions do you have about the use of speed in  
2 the high schools or in your high school? Do you have  
3 any impressions at all on this?

4 MR. McMAHON: Very few. It has been said,  
5 or at least it seems to me to be a rather isolated  
6 segment of high school life. Possibly those who have  
7 dropped out, possibly a few take it in the summer. But  
8 nonetheless, it is isolated and would form a very  
9 small minority of those would have answered our poll.  
10 Maybe those may have taken it once or twice, but it  
11 wouldn't be a major concern in any way. At least this  
12 is my impression.

13 This is not quite on our questionnaire  
14 or on the report. I would like to say something which  
15 could conceivably get me in trouble with the administration  
16 of the school. This morning myself and another person  
17 on the committee approached the administration of this  
18 school to get some time off to present our report. Now  
19 at this point we did not know exactly the time slot that  
20 we would be in to present it, but we had been told we  
21 should see Mr. Moore at about 9:30. Now, the school  
22 administration very generously said we could get off  
23 at 9:25 to try and find him. Of course, you know Mr.  
24 Moore is a very busy man and he many not just happen to  
25 be hanging around waiting for us. Also, we were told  
26 if we wanted to present our report, we would have to ---  
27 we would only be allowed fifteen minutes before the  
28 actual time slot we were in, to present the report.  
29 In other words, we would have to rush directly here  
30 from class to present it. Now we ignored both these



1 things, and we had attended all day, and we had two  
2 reasons for doing this; number one, if we had just come  
3 in fifteen minutes before we were presenting the report,  
4 we would not have been sure of the procedure we would  
5 follow; also we would not have been too sure what had  
6 been spoken previously and therefore what might be  
7 relevant for us to say. Now, there are many other students  
8 who have wanted to attend and many other students who  
9 have attended your hearings here, because they wanted  
10 also to learn something relevant and immediately relevant  
11 to their lives. However, the administration of the  
12 school again, and I suppose the School Board policy  
13 did not choose to let these people legally come and  
14 attend your hearing. So, some of these people were  
15 allowed to come by individual teachers who, on the whole,  
16 were a bit more understanding than the general administra-  
17 tion, but others like us simply had to ignore these  
18 rulings and come anyway. According to the rules of the  
19 school, this could result in anything from suspension to  
20 actual expulsion up to six home phone calls from the  
21 subject teacher from whose class you missed. And of  
22 course, this could cause hassles at home and all this  
23 sort of stuff. So this was rather bad. This condition  
24 seems to me to be rather ridiculous in a society that  
25 is supposed to be enlightened. I come to school and I  
26 think most people come to school to learn something, and  
27 I believe that one of the purposes of the LeDain  
28 Commission is to educate people to drug use. Yet, when  
29 the opportunity presents itself that the students of  
30 this school and other schools in this city, to learn





1 something which is immediately relevant to their lives  
2 right now, they are refused. Instead, the administration  
3 tells us that we must go to classes in school and learn,  
4 though memorize is probably a better word, stuff that  
5 is thrown at us which is in many cases junk and is  
6 completely irrelevant ---

7 (Applause)

8 --- to our life and this kind of seems  
9 ridiculous. I know this isn't quite on what you are  
10 doing now, but I felt possibly you might be interested  
11 in what would seem to be the rather archaic viewpoint  
12 of those in the administration pose concerning drug  
13 education and their closedmindedness, I suppose on  
14 letting the students come to these hearings.

15 DR. LEHMANN: Do you really think there  
16 will be repercussions on what you said today and what  
17 you said just now?

18 MR. McMAHON: I actually hope not now  
19 because of the publicity and so on which could become  
20 attached to it, but I have heard of cases where the  
21 administration has taken more drastic measures against  
22 less<sup>er</sup>/intrusions, I suppose, into their field of damnation.  
23 For example --- this is rather irrelevant I know --- but  
24 a couple of years ago, there was a newspaper that was  
25 attacking the school and it didn't use obscene words or  
26 anything like this, and it in a reasonable<sup>way</sup>/attacked the  
27 school and the students were told anyone caught selling  
28 this newspaper in the school would be expelled, and it  
29 was a completely legitimate magazine. But I don't  
30 think it will happen on this occasion.



1 PROFESSOR BERTRAND: What would you do if you  
2 would be one of the administrators of the school and a  
3 Commission of Inquiry into something which is, as you  
4 think, close<sup>to</sup> the life of the teenagers would be having  
5 its hearings in your school. What would you do?

6 MR. McMAHON: Well, for one thing, I  
7 would think that any student who showed a desire to  
8 come should come, or should be allowed to come and I  
9 would realize this would result in a lot of students  
10 who had no intention of coming, hooking off and so on.  
11 But I think that those who did come, it would be worth  
12 it and one day of school for some students is not going  
13 to be that much of a problem, where many students can  
14 learn many pertinent things at a hearing of this sort.

15 PROFESSOR BERTRAND: You would suspend the  
16 courses?

17 MR. McMAHON: Not unless a great majority  
18 of the people came. I suspect that today only possibly  
19 two or three hundred people tried to get permission  
20 to come and these are probably all that are interested,  
21 and of course that wouldn't be a large enough number to  
22 suspend courses. Of those two or three hundred, probably  
23 a majority of them didn't come, but nonetheless, I think  
24 they should have been granted permission.

25 PROFESSOR BERTRAND: And the teachers would  
26 give those full courses for those who wanted to be there?

27 MR. McMAHON: They just wouldn't teach  
28 them over again. A person can catch up rather easily,  
29 but on the whole the teachers have been rather cooperative  
30 on this.



1 THE CHAIRMAN: Well, certainly I would  
2 want to observe that we appreciate the facilities made  
3 available for us here in the school and it certainly  
4 is no part of our purpose to pass critical review on  
5 the responsibility of the school for its own regulations  
6 and what it judges to be in the interest of its academic  
7 programme. I would simply want to observe with reference  
8 to your own case that try as we will we are unable to  
9 schedule our appearance with such a clockwork precision  
10 as to let everybody be sure of when they will be called  
11 or how long they may have to remain, and so I think in  
12 your case I would sort of ask a certain indulgence for  
13 you, where like others here you have had to wait to be  
14 called and that is our fault and not yours, or the  
15 schools. So that, in fact, one has to spend a little  
16 more time waiting to get heard.

17 Are there any other questions or  
18 observations with respect to this submission?

19 If not, thank you very much.

20 I now call on Mrs. Mosher, Nova Scotia  
21 Federation of Home and School Associations, Mrs. Eric  
22 Mosher.

23 MRS. MOSHER: Before I begin, I think  
24 perhaps I should explain that as a member of the Nova  
25 Scotia Federation of Home and School Associations, I am  
26 speaking on behalf of about somewhere between eight and  
27 ten thousand parents. We were the first organization to  
28 develop drug education programmes throughout Nova  
29 Scotia. These programmes were about symptoms and results  
30 of drug usage. The programmes were designed for adults





1 as well as the youth, and professionals, and people with  
2 personal drug experiences were involved. As you have  
3 from  
4 just heard/ the Hi-Y, many of the young people feel  
5 that marijuana should be legalized. Perhaps the  
6 questions should be asked of them. If marijuana or its  
7 derivatives were reclassified, that is, taken off the  
8 narcotics list, how would the drug be controlled? Put  
9 under the Food and Drug Act as a restricted drug? It  
10 is my impression there would be very little change in  
11 the presently existing laws governing restricted drugs.  
12 It would still be illegal to possess or traffic in  
13 drugs, and the punishment would probably remain the  
14 same. Put under the Food and Drug Act as a controlled  
15 drug; these are usually prescription drugs and it is  
16 illegal to traffic in controlled drugs. Marijuana, so  
17 far as research shows, has no medical use, so therefore  
18 would not be prescribed by any medical person.

18 Place marijuana and its derivatives  
19 under a special law? This would have the effect of  
20 making it legal in the same manner that alcohol is legal.  
21 This would cause a great deal of controversy and trouble  
22 with foreign countries with which Canada has import or  
23 export treaties. The U.S.A. border would be the biggest  
24 problem, because of trafficking from Canada to the United  
25 States.

26 If marijuana were placed under a Special  
27 Act, how would it be sold? In government stores? In  
28 grocery stores like cigarettes? In pharmacies?

29 The young who experiment with marijuana,  
30 that is --- try it a few times; will probably suffer no



1 ill effects, except that they are breaking a Federal  
2 Law. The chronic user often exists in a state of  
3 lethargy and inactivity.

4 These people who are part of this small  
5 "drug cult" often go to harder drugs, such as LSD or  
6 the amphetamines or to heroin. Such drugs may destroy  
7 the mind. Speed or heroin may kill, the user may  
8 become addicted, and the body and mind be destroyed.

9 Recommendations: (1) We recommend that  
10 well supervised emergency centres be established in  
11 central areas with financial assistance from the  
12 Government. These centres would provide a place where  
13 people with drug problems can receive help, correct  
14 information, guidance and rehabilitation through  
15 existing welfare and social agencies.

16 (2) That the Department of Education set up in-service  
17 training for teachers on "Drug Problems and the Drug  
18 Culture".

19 (3) That judges be instructed to designate punishment  
20 that will benefit the person convicted on drug charges.  
21 That sentence on conviction be stricter, not less.  
22 Fining the drug offender is not the answer.

23 (4) Once a person is convicted on a drug charge there  
24 should be a follow up through the probation service,  
25 with family involvement and guidance.

26 The Canadian Home and School Parent  
27 Teacher Federation of which our Federation is a member  
28 does not approve the legalization of marijuana. The  
29 Canadian Home and School Parent Teacher Federation  
30 opposes reduction of the penalty for drug traffickers,



1 Thank you.

2 THE CHAIRMAN: Thank you.

3 MR. STEIN: What would your view be on  
4 looking at recommendation 3, about the kind of sentence  
5 that would benefit the person convicted on drug charges?

6 MRS. MOSHER: Well, for instance, now on  
7 the drug user, the person is charged and either a  
8 suspended sentence or \$100.00 fine, which he invariably  
9 makes the next day selling marijuana. I would suggest  
10 that, perhaps, rather than a jail term or \$100.00 fine,  
11 that perhaps the drug user should be sent to a mental  
12 institution to see what has happened to some of the youth  
13 that has become too involved in drugs. I feel that  
14 there should be rehabilitation, some follow up, not just  
15 to have somebody appear in court and then the next day  
16 go back to his old habit.

17 MR. STEIN: I notice that at the top  
18 of the page you make some distinction between the person  
19 who uses it a few times and the chronic user. Do you  
20 feel that if an individual is apprehended for drug  
21 possession, should there be some effort to determine  
22 whether he is a chronic user or whether he has used it  
23 a few times?

24 MRS. MOSHER: I feel there should be.

25 MR. STEIN: Or if he is a casual user,  
26 let's say?

27 MRS. MOSHER: I am sure that if you've  
28 tried it two or three times, the third time you try it  
29 you are caught, and it is a Federal offence at this  
30 time, and I think that through rehabilitation and follow





1 up service, this should be investigated before, perhaps,  
2 a young person is at this time put in jail.

3 MR. STEIN: This is an unfair question,  
4 but were you here earlier?

5 MRS. MOSHER: Yes.

6 MR. STEIN: A lot of the discussion  
7 earlier was around the question of speed use, and the  
8 comment was made by quite a number of people, even  
9 people who were worried or concerned by speed use,  
10 that compulsory treatment of persons using drugs that  
11 might like to try it, seemed to --- help. Do you feel  
12 we should have gone along anyway not knowing what the  
13 outcome would be?

14 MRS. MOSHER: I think it is far better  
15 than what is going on now, a jail sentence for a speed  
16 user. Speed is something that I am afraid of as a  
17 parent, as a mother, and I would like to think that if  
18 my child was involved with any of the amphetamines,  
19 that rather than being sent to jail into an environment

20 perhaps where they would have even more problems or  
21 perhaps be rehabilitated, and if necessary, compulsory  
22 psychiatrists analysis and rehabilitation would follow  
23 up. I know I heard the gentleman say that he did not  
24 feel you could force people to come off speed, and I  
25 agree with him. But it is like an alcoholic. You have  
26 to want to. But I think it is worth a try, and we are  
27 not getting far the way things are now.

28 MR. STEIN: One other question: are  
29 your recommendations regarding the law directed to all  
30 ages or to persons under eighteen or under twenty-one?



1 Do you have the same concern for person over the age of  
2 eighteen who are using cannabis ---

3 MRS. MOSHER: Yes. I would refer to all  
4 age groups.

5 MR. STEIN: To all age groups?

6 MRS. MOSHER: Yes.

7 THE CHAIRMAN: Could you tell me how  
8 these recommendations have been developed, Mrs. Mosher?

9 MRS. MOSHER: Yes. I drew them up,  
10 actually, not word for word as they are, in the spring.  
11 About two years ago I became involved in drug education  
12 throughout Nova Scotia because I was a member of the  
13 Health Committee, and we have an annual convention in  
14 June and this is representation from all of Nova Scotia  
15 and these recommendations were passed in principle at  
16 that time.

17 DR. LEHMANN: I am not very clear about  
18 what you mean by the drug offender. In the last sentence  
19 you say that the Canadian Home and School Parent Teacher  
20 Federation opposes reduction of penalty for drug  
21 traffickers. But then, under drug offender, since you  
22 say before that fining a person is not the solution and  
23 so on, you seem to include also the user of, let's say,  
24 cannabis, which is at the present time against the law,  
25 and then you speak of compulsory treatment as you just  
26 did now for speed users, and that is not a drug offender,  
27 the speed user, so would you propose that the law be  
28 changed and more drug offender categories be created to  
29 include the speed user?

30 MRS. MOSHER: Perhaps drug offender is not



1 the word I should have used. Perhaps the person charged  
2 with the drug offence.

3 DR. LEHMANN: Well, they would not be  
4 charged with a drug offence, the speed user?

5 THE CHAIRMAN: I think the difficulty  
6 here Mrs. Mosher is to understand what you include  
7 under drug charges in (3). You know there is trafficking  
8 and simple possession for use, and I think we are  
9 concerned to know whether your recommendation at the  
10 end of (3) applies to simple possession for use.

11 MRS. MOSHER: Yes, just probably fine  
12 the drug offender who is only charged on possession ---  
13 perhaps that should be included. The last sentence on  
14 the last page, the Canadian Home and School, this is  
15 national. It is something that the National Home and  
16 School recommended at their National Convention, which  
17 I had nothing to say about except that the recommendation  
18 came from here. They specifically said drug traffickers  
19 as you will notice. I think when I am speaking of (3)  
20 I am referring to the drug possessor, fine the drug  
21 possessor.

22 THE CHAIRMAN: Do you mean it is your  
23 view, or your Federation's view that the simple possession  
24 of cannabis should be punishable by imprisonment?

25 MRS. MOSHER: No, I am saying that fining,  
26 which is what they are doing now, is not helping, even  
27 the person who is in possession, fining them \$100.00 is  
28 not teaching them anything. It is almost like a boot-  
29 legger that is picked up and it is a free ad that he  
30 has ---





1 THE CHAIRMAN: The previous sentence  
2 states that "sentence and conviction be stricter, not  
3 less. Fining the offender is not the answer." You are  
4 opposed to fining as such, and your alternative is  
5 then, imprisonment.

6 MRS. MOSHER: Do you want me to comment  
7 on that? You are getting me more and more mixed up.  
8 That is what you are doing.

9 THE CHAIRMAN: Well I hope not, it is  
10 certainly not my intention or desire. I want to make  
11 sure that I understand the precise meaning of the  
12 Federation, because it represents eight to ten thousand  
13 parents, and I want to understand what it is saying  
14 to us. I am not trying to confuse you or trap you or  
15 anything of that sort. It is just the two sentences  
16 right together, and I want to know what other meaning  
17 we could give them. If there is another intent, by all  
18 means we should know it and record it.

19 MRS. MOSHER: I am sorry, perhaps I am  
20 confusing you. We feel that right now sentences are  
21 being suspended where there has been a fine, and by  
22 stricter conviction I would say, either that --- I feel  
23 very strongly there should be a follow up, rehabilitation  
24 and if the stricter sentence means that somebody has to  
25 perhaps go as a worker in a Nova Scotia mental institu-  
26 tion for a month, let this be the penalty. To me this  
27 would be stricter than <sup>a</sup>/\$100.00 fine. It would be more  
28 meaningful.

29 THE CHAIRMAN: In other words, should we  
30 read 4) in a sense with (3)? Is the thought in (3)



1 completed by (4) which reads, "once a person is  
2 convicted on a drug charge, there should be a follow  
3 up and guidance". So we are not to understand (3) as  
4 advocating imprisonment for simple possession?

5 MRS. MOSHER: No.

6 THE CHAIRMAN: Are there any other  
7 questions?

8 MRS. MOSHER: I do wonder --- I would  
9 like your opinion if marijuana was legalized, how it  
10 would be controlled?

11 THE CHAIRMAN: Well we only are supposed  
12 to give our opinions in the form of a report. The next  
13 time we express them will be in the final report I  
14 guess.

15 MRS. MOSHER: Seven hundred pages, I  
16 hope not.

17 THE CHAIRMAN: In the light of what was  
18 said in the last brief, I think we will have to give  
19 serious thought to being as succinct as we can.

20 MRS. MOSHER: Thank you.

21 THE CHAIRMAN: Thank you very much.

22 Now I call upon --- excuse me. Yes  
23 Dr. Segal?

24 DR. SEGAL: I would just like to make  
25 one comment on Dr. Lehmann's comment when he said that  
26 there were very few things in marijuana that could prove  
27 harmful. There are things that have been found in  
28 marijuana which could be slightly distressing, and this  
29 is one thing we found when we still had the potential  
30 of analyzing substances. And this was a sample of



1 marijuana dusted with ergot alkaloids, and the person  
2 smoking marijuana expected what they would get from  
3 marijuana, but obtained something similar to what they  
4 would have if they were to ingest LSD.

5 THE CHAIRMAN: Thanks. Yes?

6 THE PUBLIC: I had a number of things I  
7 wanted to say.

8 THE CHAIRMAN: Yes. We had another  
9 submission scheduled. Mrs. Moore, Community Action  
10 Group from Truro, but by all means if you would wish  
11 to, go ahead.

12 THE PUBLIC: If she is not present.

13 THE CHAIRMAN: Is Mrs. Moore present?

14 MRS. MOORE: Yes.

15 THE CHAIRMAN: Well, would that be all  
16 right and then we would be glad to hear from you?

17 THE PUBLIC: Yes.

18 THE CHAIRMAN: Mrs. Moore, would you like  
19 to come to the table?

20 MRS. MOORE: The Community Action Group  
21 of Truro in Nova Scotia which I represent is made up of  
22 concerned parents and interested people. We feel that  
23 the visible effect of drug usage is becoming more acute.  
24 There is every indication that the non-medical use of  
25 drugs is on the increase. Our local law enforcers claim  
26 that there is four times as many this year as compared  
27 with the previous year. There is also lowering of the  
28 moral standards of our youth. Take note of the increase  
29 in illegitimate births and the high incidence of venereal  
30 disease.





1 THE PUBLIC: Could you speak closer into  
2 the microphone please?

3 MRS. MOORE: Yes. Did you hear that or  
4 would you like it repeated?

5 THE CHAIRMAN: I think you have to speak  
6 closely to the microphone, Mrs. Moore.

7 MRS. MOORE: Should I go over it again?  
8 Well, the Community Action Group of Truro, Nova Scotia,  
9 which I represent, is made up of parents and interested  
10 people. We feel that the visible use of drug use is  
11 becoming more acute. There is every indication that the  
12 non-medical use of drugs is on the increase. Our local  
13 law enforcement officers claim there are four times as  
14 many arrests this year as compared to the previous year.  
15 There is also a lowering of the moral standards of our  
16 youth. Take note of the increase of illegitimate births  
17 and high incidence of venereal disease. We have  
18 recommendations. The punishment should fit the crime.  
19 Rather than suspended sentence and fine, a follow up  
20 programme and some plan for rehabilitation. This year  
21 the drug crisis centre was planned, and operated during  
22 the month of August in Truro. The public feelings on  
23 this trial project are that the centre was not adequately  
24 supervised nor adequately staffed and had misguided  
25 support. We would recommend that any service centre be  
26 concerned with both drug and alcohol abuse, and that  
27 any such centre be attached to our local hospital. In  
28 the past year, our Community Action Group have organized  
29 and sponsored three drug education programmes for parents  
30 and teenagers.

. . . (portion inaudible) treatment centres that are  
part of the



1 hospitals and are much more willing to go to centres  
2 that are staffed and managed by young people, that are,  
3 albeit, rather informal.

4 MR. CAMPBELL: Recently, I heard testimony  
5 elsewhere of a hospital that was receiving two out  
6 patients a week and very close to it, two youth operated  
7 centres, two psychiatric consultants that were receiving  
8 about fifty a week. Now this raises some questions and  
9 if this situation is general, is it still advisable to  
10 confine the service to the hospitals?

11 MRS. MOORE: I think the reason we said  
12 this was because the staff at the crisis centre were  
13 not adequately trained and they were dispensing valium,  
14 I believe it was, to someone that was high. I can't  
15 see a lay person dispensing drugs. I think it should  
16 be under better supervision.

17 MR. CAMPBELL: Is this the essence of  
18 your criticism, the prescribing of drugs by lay people?

19 MRS. MOORE: Yes.

20 MR. CAMPBELL: If it weren't for this  
21 factor, do you have any objections to this type of  
22 centre?

23 MRS. MOORE: No.

24 MR. CAMPBELL: To what extent do you  
25 think young people, people who have an intimate familiar-  
26 ity with the drug scene, should be involved in these  
27 centres?

28 MRS. MOORE: I think they are the ones  
29 that should be involved because our generation doesn't  
30 know too much about the drug scene.



1 MR. CAMPBELL: You made the statement  
2 that the punishment should fit the crime. But at least  
3 in my notes, you haven't elaborated on that. Could you  
4 elaborate on the type of appropriate penalty or fitting  
5 penalty that you would see in the drug offences?

6 MRS. MOORE: Not wanting to pinpoint it  
7 in Truro alone, we have had convictions that were just  
8 a fine and suspended sentence, and the child or teenager  
9 became a hero in the eyes of the other children in the  
10 town. I think that there should be some way not to  
11 punish them, really; to teach them; to educate them that  
12 they haven't pulled the wool over our eyes; that we  
13 do want to help them. I can't see it being an institution.  
14 I am not qualified to say just what it should be, or  
15 what I would like done with my own children if they  
16 were in that situation. I am at a loss to tell you.

17 THE CHAIRMAN: But, I gather, Mrs. Moore,  
18 that you feel the Government should attempt to organize  
19 some system of follow up or rehabilitation, in effect,  
20 compulsory treatment?

21 MRS. MOORE: I think rehabilitation is  
22 our big problem. We don't have any facilities for  
23 rehabilitation.

24 THE CHAIRMAN: If you were to be satisfied  
25 that in a particular type of drug use, or drug effect,  
26 there was really no thing you could call treatment in  
27 any medical sense, in many cases, and no real thing you  
28 could call cure, would you still want some confinement  
29 for the simple use of that drug, simple possession for  
30 use of that drug?





1 MRS. MOORE: Not confinement, I wouldn't  
2 want confinement unless it was going to be curative or  
3 rehabilitative.

4 THE CHAIRMAN: You would want it to  
5 be shown to be truly curative?

6 MRS. MOORE: Or rehabilitative.

7 DR. LEHMANN: Suppose it can't be shown  
8 until it has been enacted for perhaps two or three  
9 years and you have tried it out, because so far there  
10 just isn't any evidence that it is. Now, how would you  
11 go about this? Would you have to have a law first for  
12 compulsory treatment, while on the other hand you didn't  
13 want that, unless it is shown to be effective. You  
14 are in a bind there.

15 MRS. MOORE: Maybe it should be compulsory  
16 for a number of years until we can draw up a study, that  
17 will show just how effective it is.

18 DR. LEHMANN: And if it is then found  
19 it is not effective, you would abolish the law?

20 MRS. MOORE: Yes.

21 DR. LEHMANN: In other words, you would  
22 then take a risk that perhaps it wasn't effective and  
23 take the slight chance that it might be effective and  
24 be quite prepared then to drop the procedure if it  
25 isn't effective?

26 MRS. MOORE: Yes.

27 DR. LEHMANN: The effect being people  
28 would undergo treatment in some sort of clinical  
29 institution that they might not like, and perhaps the  
30 parents wouldn't like. You would be prepared to accept



1 it if your own children would be ---

2 MRS. MOORE: If I thought someone was  
3 trying to help them, I would be prepared for that.

4 THE CHAIRMAN: Any other questions or  
5 observations?

6 Yes. Would you go to the microphone,  
7 please?

8 Thank you.

9 THE PUBLIC: Mr. Chairman, these are  
10 more observations than anything. I was just wondering  
11 if you have ever been conscious of the fact that the  
12 many articles written about drugs have made a lot of  
13 our young people very interested in them. And they have  
14 wanted to try, and in my own son's case, he said, when  
15 I asked him why he indulged in drugs -- he said, "It  
16 had been written so many times", and it had looked so  
17 interesting to him, he wanted to know what it was all  
18 about. So he went to a library and Timothy Leary's  
19 Mind Expansion, evidently, was the book he got, and he  
20 said this has happened with a lot of his friends. They  
21 become so interested in all of these articles, that they  
22 want to know what it is all about. So maybe in our  
23 attempt to disillusion them about the drugs, we have  
24 probably done just the opposite. And the only other  
25 comment I would have would be about the convictions.  
26 Often, I find that <sup>is</sup> it/ not the child or the young teenager  
27 who was picked up as a result of possession who  
28 suffers, it is the parent. Father immediately pays out  
29 the \$100.00 find and that is all there is to it. And  
30 I am wondering if this is the answer to the problem at



1 all? These are just a couple of observations that I  
2 had found out by dealing and talking with the children  
3 that are on drugs. It is a problem and only a parent  
4 who has actually been in contact with it knows how it  
5 can upset the entire family. It is something for all  
6 the people. The other thing I want to talk of, it  
7 dates me a little bit, but it takes a thief to know a  
8 thief, and the only thing that can actually help the  
9 young people are the people who know drugs themselves  
10 and have had the actual experience. But I do feel they  
11 should be governed. But, when they say a person is an  
12 ex-speeder when he isn't<sup>an</sup>/ex-speeder, and he is  
13 working with the people, and assuming they know he is  
14 not an ex, and he is still using, not only speed, but  
15 any other one of the drugs, and I find this does  
16 happen in the organizations. This is something you  
17 can't prove; you can only go by what you hear from the  
18 young people on the street.

19 Thank you very much.

20 THE CHAIRMAN: Thank you.

21 THE PUBLIC: I would just like to add a  
22 little bit to my comments this morning. I didn't get  
23 around to the innovative services, and I think the  
24 reason for this is one can talk about this subject for  
25 a long time. I know this lady from Truro and other  
26 people who are very distressed at some of the innovative  
27 services that have been started. I don't know if this  
28 would be any reassurance to them, or reassurance to  
29 anybody, but the fact is these people are trying some-  
30 thing new and they are trying something that they are





1 not sure about what they are doing, and many of these  
2 people, having been through the drug scene, are perhaps  
3 still involved in the drug scene, are making mistakes;  
4 they are not professionally trained, and they are just  
5 feeling their way along. I think at times this might  
6 arouse a considerable amount of distress in the communities,  
7 but I don't think they should be condemned for this. I  
8 think the whole thing comes down to how much are they  
9 learning from their mistakes; how much are they  
10 publicizing their mistakes, and how much are they  
11 preventing other people from making similar mistakes,  
12 or going up similar blind alleys. I think these  
13 innovative services are completely valid and I think  
14 they are potentially extremely helpful, and as a  
15 psychiatrist I know there are many times I have ex-  
16 perience failure, and the innovative services have a  
17 great deal of success and I am delighted at their  
18 existence, and I am delighted they carry on.

19 THE CHAIRMAN: Thank you.

20 THE PUBLIC: The word "rehabilitation"  
21 distresses me. But it bothers me particularly when it  
22 is used to talk about the question of marijuana. Because  
23 when you say instead of jail sentences you should have  
24 rehabilitation, that assumes that people are doing  
25 something wrong, and they have to be rehabilitated; they  
26 need to be shown the light; that they have to come and  
27 live the way the adults are living. It is sort of like  
28 the adults --- nobody talks about rehabilitation for  
29 social drinkers or rehabilitation for people using  
30 cigarettes or compulsory confinement for amphetamine



1 addiction. And it seems to be pretty much the adult  
2 saying, "We have our forms of enjoyment and pleasure,  
3 and since we have the power we are going to keep this  
4 legal, but you have your forms of enjoyment, and since  
5 you don't have any power, then we are going to make  
6 those illegal, and you have to see the light and do  
7 things the way we are doing them in order to be a 'good  
8 citizen'". It just seems to me that maybe if you make  
9 a clear distinction between marijuana and addicting  
10 drugs, that you also make a distinction between a chronic  
11 user and a social user, then there is very little reason  
12 why a social user of marijuana should need to be  
13 rehabilitated or sent to a mental institution to see  
14 where he is going wrong, except for the fact that that  
15 is the way our laws are set up now. But if people  
16 could accept the fact that marijuana has been proved,  
17 not proved but likely has very few ill effects, or at  
18 least not as many effects as alcohol and tobacco, which  
19 it seems to me, that the young people might accept a lot  
20 more, some of the dangers of some of the other drugs.  
21 But as long as you lump them altogether and you say  
22 everything is bad, then the kids will say, "I have tried  
23 smoking grass, it does not seem to me to be bad, they  
24 must be wrong about everything else too."

25 THE PUBLIC: I am a worker in Halifax  
26 with Headquarters and there is one point that has been  
27 bothering me all afternoon: the whole idea of compulsory  
28 confinement, and I know from experience during the summer  
29 that whatever kids we have helped, the main reason we  
30 have been able to do it, is that they have been able to



1 trust us, that we would not go to the police or their  
2 parents, or anything else like this. Now if kids are  
3 going to hear that if they are going to come in and they  
4 are going to see a psychiatrist and possibly be confined  
5 against their will in an institution, you are going to  
6 lose your contact. Because a lot of the contacts I have  
7 are on a very easy level because they know we can be  
8 trusted, and so it is very confidential information  
9 and they are not forced to do anything. And there are  
10 very few kids that are certain enough about wanting to  
11 quit that they will have themselves compulsorily  
12 confined. This would alienate a lot of kids. They will  
13 say, "I am not going down there, because I could end up  
14 for a year in an institution". They will say, "I do not  
15 want that. I just want to be helped".

16 THE CHAIRMAN: Thank you.

17 There is a gentleman down here who was  
18 going to speak to us a while ago.

19 MR. LAPRES: I should begin by telling  
20 you name. I am Dan Lapres from Dalhousie High School  
21 and I made a presentation before you in, I believe, it  
22 was February when you were through here last year, and  
23 briefly to just reiterate what I said then, as I say,  
24 in a very summary way, I was attempting to say that the  
25 only ground as far as I was concerned on which a law  
26 against the use of drugs could be justified was that  
27 that drug was physically harmful to the people that  
28 took it. That was the only ground on which it could be  
29 justified. And any suggestion that the consumption of  
30 drugs was morally offensive, was irrelevant to the





1 question of whether they should be legal, and there  
2 should be no criminal punishment imposed on someone  
3 because he is hurting someone elses morality.

4 This summer, along with a girl in  
5 sociology taking her Masters, we did a study, an  
6 empirical study trying to bring out particular points.  
7 We also delved into some of the more general questions,  
8 how many people are in favour of legalization of drugs,  
9 which drugs, what age and so on. I don't want to take  
10 up your time on very general things, but what I would  
11 like to do is just abstract some points in this survey  
12 that we conducted, which I think may, perhaps, be bits of  
13 information that you have not received before, or if you  
14 have, you might want to compare them with results  
15 received elsewhere.

16 I should preface this by saying that  
17 our sample consisted of 125 university students at the  
18 University of Dalhousie, and at St. Mary's University.  
19 Eighty of them were males and forty-five females, if  
20 that makes any difference, and 77% of the males were  
21 users, and 60% of the non-users were males. So as to  
22 consumption, there is not a big difference whether you  
23 are a male or female. We investigated to try and find  
24 out whether the people that were involved in drugs thought  
25 that it was easier to obtain marijuana than to obtain  
26 speed, and we found that there is very little that  
27 people know about the availability of speed and the  
28 availability of grass. People just do not seem to know  
29 which is more available. We also asked whether people  
30 would begin to use marijuana, or begin to use speed,



1 if either of them were legalized. 71% of people who  
2 take marijuana said if it were legalized, they would  
3 increase their use. 13% of the non-users, said they  
4 would begin using grass if it were made legal. Perhaps  
5 one of the more interesting points of the survey was  
6 that we took up the question of contagion, and in response  
7 to the question of whether or not there would be a  
8 tendency to turn to speed, given the possibility of an  
9 increased access to grass, only 1% of the people said  
10 that they would ever try speed. In other words, as far  
11 as these people were concerned, there was no association  
12 between access to grass and moving on to speed. Another,  
13 I think, significant finding is that --- at least  
14 contrary to my own belief prior to the survey --- people  
15 who use grass are not more informed about drugs than  
16 people who don't. We categorized people in terms of  
17 the degrees of their information as being either unin-  
18 formed, thoroughly informed, well informed or very  
19 well informed and quizzed them on whether they had ---  
20 whether their sources of information were friends,  
21 whether they were newspaper reports, whether they were  
22 from special lectures, books, the LeDain Commission, and  
23 so on, and the conclusion was that definitely non-users  
24 at least in this sample, were if anything better informed  
25 than were the users. This takes on a particular  
26 relevance I think, because we also were interested in  
27 what were the motivating factors behind people's decisions  
28 as to whether they would take drugs or not take drugs.  
29 We asked them specifically what the effect of the law  
30 against drugs was, was this a deterrent. We asked if



1 morality was a consideration, and we asked whether  
2 physical effects were in fact a major deterrent, or the  
3 lack of physical harm, the straw that was finally  
4 broken and paved their way to taking drugs, as it were.

5 I would just like to read to you this  
6 particular part of the study, and as I say it might be  
7 of some value to you. Investigating the reasons  
8 influencing the users attitude towards the use of drugs,  
9 70% indicated a desire to try something new, 84% agreed  
10 to the sub-culture influence, 78% agreed that the lack  
11 of evidence of the harmful effects of marijuana was a  
12 contribution --- contributing factor to this attitude  
13 on marijuana use. 92% of the users agreed that the use  
14 of marijuana was not morally wrong and this too influenced  
15 their desire to use grass.

16 PROFESSOR BERTRAND: These were closed  
17 questions. You provided alternatives did you?

18 MR. LAPRES: Yes we did. I will be  
19 providing you with copies of this survey. Would you  
20 like me to provide ---

21 PROFESSOR BERTRAND: I think it is all right  
22 that way.

23 MR. LAPRES: All right. Now, when we  
24 asked them what the single greatest factor was of their  
25 decision not to take drugs, the users --- 40% of the  
26 users indicated that the greatest influence was the  
27 lack of the possible harmful effects derived from the  
28 consumption of drugs. 33% of the users indicated desire  
29 based on failure to see marijuana as a moral question,  
30 and another 26% thought it was morally not wrong to this





1 extent where stepping --- making the point that they  
2 would act against --- act because they felt it was not  
3 morally wrong. So in other words, 40% of the people who  
4 take marijuana, out of this survey, were influenced  
5 primarily by the fact that they do not believe there  
6 are any physical harmful effects deriving from the use  
7 of marijuana, and 60% felt that the main consideration  
8 overall was morality, if you will.

9 THE CHAIRMAN: I am finding it difficult  
10 to follow. You said the single greatest factor influencing  
11 the decision as to whether or not to take a certain drug,  
12 and I take it you are referring to marijuana ---

13 MR. LAPRES: Yes I am, sir.

14 THE CHAIRMAN: --- is whether or not  
15 there is harmful effect. And then you said 60% and you  
16 said that represented 40% of the responses.

17 MR. LAPRES: I am sorry, I did not mean  
18 to confuse you. The single greatest factor was 40% on  
19 the physical effects. The 60% was evenly divided between  
20 two questions, both associated with morality. In each  
21 of those two questions, the students replying indicated  
22 that the use of drugs was simply not a moral question  
23 and that they were not going to be influenced by morality,  
24 or else they thought that the issue was a moral question  
25 but it was <sup>not</sup> morally wrong.

26 THE CHAIRMAN: That is what I cannot  
27 follow. It seems ---

28 MR. LAPRES: In other words, you can  
29 say, if you consider it a moral question ---

30 THE CHAIRMAN: All right. 40% thought



1 the most relevant criterion was potential for harm, and  
2 60% thought the most important criterion was morality?

3 MR. LAPRES: That is right. One way or  
4 another on morality. Now to similar questions for not  
5 using grass, 90% of the non-users indicated they did  
6 not need any such stimulation. 31% of the non-users  
7 agreed to the influence of sub-culture, their friends  
8 telling them not to. 60% indicated the influence was  
9 possible harmful effects, 56% felt the greatest factor  
10 was the illegality of marijuana, and 32% because it is  
11 morally wrong. So, the single greatest factor in  
12 deterring people is the illegality.

13 Excuse me --- the single greatest factor  
14 deterring people from using marijuana is the possible  
15 harmful effects, in our opinion.

16 THE CHAIRMAN: We will have to go back  
17 there because I have lost you now. I have got 40% ---  
18 is this 40% of all your people?

19 MR. LAPRES: That is right.

20 THE CHAIRMAN: 40% of all responses,  
21 users and non-users?

22 MR. LAPRES: This is non-users.

23 THE CHAIRMAN: All right. Now as I  
24 understand you, 40% of the non-users thought that the  
25 most important relevant ---

26 MR. LAPRES: No. The first set of  
27 information that I was giving you on the non-users is  
28 simply a series of questions that we directed at people  
29 and said do you agree or disagree. Then we got down  
30 and said, "Which of those things is the most important to



1 you? Now, you might for example say that you agree that  
2 the harmful effects have influence on you, that the  
3 influence of your friends has been of some weight, but  
4 which factor has been the most significant to you?" And  
5 of the non-users, 56% were not worried because of  
6 harmful results, 28% because of the illegality and  
7 16% because of morality. Now, I am trying to draw  
8 your attention to the emphasis on the physically harmful  
9 effects, and the reason that I think this is significant  
10 is because, what this suggests to me is that not only  
11 on a philosophical or abstract level as I stated last  
12 March, is it true, that the only criterion on which a law  
13 on drugs should be based, is that of physical harmful  
14 effects, but in fact in political terms if you will,  
15 or realistic terms or in terms of influencing people  
16 or education people, I am suggesting to you that the one  
17 area that you have to direct your attention to primarily  
18 is on the physical harmful effects or the non-physically  
19 harmful effects.

20 DR. LEHMANN: You did have 30% ---  
21 28% that you considered the law was a deterrent, which  
22 is almost a third?

23 MR. LAPRES: That's right.

24 DR. LEHMANN: Those were effectively  
25 deterred?

26 MR. LAPRES: That's right, 28% of the  
27 non-users. Of course, in this sample of 125 students,  
28 47 of them used drugs to begin with.

29 THE CHAIRMAN: So 47 plus 56% of the  
30 balance were not deterred?





1 MR. LAPRES: That is right. What I am  
2 submitting is the law is relatively a secondary considera-  
3 tion for most people. Of course we all know this anyway  
4 I suppose, but it's nice to see it in fact.

5 THE CHAIRMAN: How many of the users  
6 were influenced by the question of harm?

7 MR. LAPRES: Of the users, 40%.

8 THE CHAIRMAN: I understand that to  
9 mean, if they persuaded that there were harmful effects  
10 they would not have used the drug?

11 MR. LAPRES: That is correct.

12 THE CHAIRMAN: So 40% of the users said  
13 they were influenced by their assumption as to harm  
14 and 50% of the non-users said they were influenced by  
15 their assumption as to harm?

16 MR. LAPRES: That is correct.

17 DR. LEHMANN: So their votes could be  
18 shifted according to the scientific information that  
19 becomes available?

20 MR. LAPRES: That's right. And just to  
21 add an added emphasis to your role in this area, in this  
22 survey 73% of the people who used drugs are aware of  
23 your recommendations and 53% of the non-users are. So  
24 that means that people know about what you are doing,  
25 and they are waiting for you to tell them what your  
26 findings are. And I am suggesting the physical effects  
27 is really the crunch issue, both at a philosophical and  
28 at a practical level.

29 There are just a couple of other things  
30 I wanted to draw your attention to: 72% of the entire



1 sample in this case was in favour of the legalization of  
2 marijuana. As to ages, we gave them ages sixteen,  
3 eighteen, nineteen and twenty-one, and the largest  
4 age choice was eighteen. 31% of the people who wrote  
5 in favour or who chose legalization of marijuana, said  
6 the age should be eighteen, which is an important  
7 consideration, I think, when we think that the number of  
8 people involved in drug use are probably primarily in  
9 juvenile ages.

10 THE CHAIRMAN: There should be an age  
11 limit of eighteen? 31% said that?

12 MR. LAPRES: That's right.

13 THE CHAIRMAN: 31% of those in favour of  
14 legalization?

15 MR. LAPRES: That's right, plus the 72%.

16 THE CHAIRMAN: What other views were  
17 there?

18 MR. LAPRES: Of the users, 10% voted for  
19 under sixteen; 8% for sixteen; 13% for eighteen; none  
20 for nineteen; and 10 for twenty-one. 10% that is. Of  
21 the non-users, nobody was in favour of legalization for  
22 people under sixteen. 1% was in favour of legalization  
23 for the age of sixteen; 25% were in favour of it at  
24 eighteen; 4% at nineteen, and 12% at twenty-one. Total  
25 figures, 31% agreed to eighteen.

26 THE CHAIRMAN: What happened to the  
27 balance of --- I guess I lost track of that. 31% were  
28 in favour of eighteen, what did the other 69% have to  
29 say?

30 MR. LAPRES: 24% agreed to under sixteen;



1 19% agreed to sixteen; 31% agreed to eighteen, and 34%  
2 agreed to twenty-one, total figures.

3 THE CHAIRMAN: Was there any space for  
4 those who didn't think there should be any age limit?

5 MR. LAPRES: That's right. Under  
6 sixteen.

7 THE CHAIRMAN: But that is an age limit?  
8 Was the choice not offered of answering the question  
9 without age limit?

10 MR. LAPRES: Yes. Oh, I see. Well,  
11 that question was not asked on the assumption that for  
12 all intents and purposes ---

13 THE CHAIRMAN: There wouldn't be an age  
14 limit?

15 MR. LAPRES: If you have an age limit  
16 under sixteen, say, at twelve years old for all intents  
17 and purposes that is not an age limit at all.

18 THE CHAIRMAN: From what I understand,  
19 under sixteen, <sup>you</sup> mean no one under sixteen shall be  
20 able to have it?

21 PROFESSOR BERTRAND: Opposite.

22 MR. LAPRES: The age limit would be  
23 twelve or fourteen.

24 THE CHAIRMAN: Something under the age  
25 of sixteen?

26 MR. LAPRES: That is right.

27 THE CHAIRMAN: I misunderstood.

28 MR. LAPRES: Just a couple more  
29 considerations, and that is, we asked people what  
30 system of distribution they would be interested in, if





1 drugs were legalized. If you were to make a recommendation  
2 on the legalization of marijuana, I would assume you  
3 would also want to make a recommendation on how it should  
4 be controlled. And of the users, 35% favoured a system  
5 where it was sold at cost, plus taxes to cover rehabili-  
6 tation, things like this, in other words similar to  
7 the alcohol taxes.

8 THE CHAIRMAN: You mean rehabilitation  
9 of the users?

10 MR. LAPRES: Of users or drug centres  
11 or so on. 33% of the non-users were in favour of a  
12 similar kind of system, so the conclusion on that is,  
13 if there is to be a legalization of marijuana, that  
14 people that are in favour of a distribution analogous  
15 to that for liquor.

16 THE CHAIRMAN: Government control of  
17 distribution?

18 MR. LAPRES: Yes sir.

19 THE CHAIRMAN: Government outlet?

20 MR. LAPRES: That's right.

21 THE CHAIRMAN: How many in favour of  
22 that? What proportion?

23 MR. LAPRES: Sixty out of 120. Over  
24 50%.

25 THE CHAIRMAN: Right.

26 MR. LAPRES: As to the legalization of  
27 speed, there was absolutely no support for that  
28 proposition at all to mention. I think that is about  
29 all that I wanted to draw your attention to.

30 DR. LEHMANN: But speed is legal now.



1 PROFESSOR BERTRAND: Yes.

2 THE CHAIRMAN: You mean possession is not  
3 prohibited?

4 MR. LAPRES: We put the question to them  
5 in the context of, if you could illegalize speed, or are  
6 you in favour of having speed legal? In other words,  
7 not telling them speed is or is not legal, but do you  
8 favour such a proposition, that it should be legal?

9 DR. LEHMANN: Would that mean then that  
10 the majority would be in favour of having it illegal,  
11 including possession?

12 THE CHAIRMAN: We are using legalization  
13 in different ways here. When you speak of legalization  
14 of marijuana, you are talking about legal, and in your  
15 sense, Government controlled distribution.

16 PROFESSOR BERTRAND: Not only.

17 THE CHAIRMAN: Government authorized use.  
18 And if you are talking about there is no prohibition  
19 against the simple possession of speed, but there is a  
20 prohibition against unauthorized distribution of  
21 amphetamines, that is, without prescription. So that  
22 when you speak about the legalization of speed, do you  
23 mean the authorized distribution of it, or do you simply  
24 mean the authorized possession of it, simple possession?

25 MR. LAPRES: Possession.

26 THE CHAIRMAN: Which is the situation  
27 now. So what inference do we draw from that they are  
28 not in favour of "legalization" of speed. Are we to  
29 draw the inference that they are in favour of the  
30 simple possession being prohibited?



1 MR. LAPRES: That's right.

2 THE CHAIRMAN: Have you any percentages  
3 there?

4 MR. LAPRES: Of the users, and I mean  
5 marijuana users, there is no one who agreed that  
6 legalized speed is acceptable. 46 --- in other words,  
7 who  
8 all of the users/answered this question, said that it  
9 should be illegal. 72 out of 75 people who do not use  
10 any drugs at all, said speed should be illegal for  
11 possession.

12 Now, as to treatment ---

13 THE CHAIRMAN: That is not the way your  
14 question was framed. I mean, we are going to see your question-  
15 naire, but you used the word "legalization", didn't  
16 you? What was your question on the use of speed?

17 MR. LAPRES: Drug by prescriptions are  
18 to be legal.

19 THE CHAIRMAN: And 72 out of 75 said  
20 no.

21 MR. LAPRES: With respect to treatment,  
22 marijuana users, 100% of them said that the proper  
23 treatment for drug cases, whenever it is necessary,  
24 is rehabilitation, and 91% of the non-users gave  
25 similar answers. In other words, people are generally  
26 in favour of rehabilitation, and punishment is not a  
27 factor in how you deal with the problem of drugs. On  
28 the power of the police to control the use of drugs,  
29 73% agreed to increasing police powers regarding the  
30 control of marijuana. 18% felt police powers regarding  
the control of marijuana should remain unchanged, while





1 90% indicated agreement to decreasing police powers.

2 So that the police seem to be well regarded, and it  
3 would appear people are interested in having more police  
4 protection even with respect to marijuana.

5 DR. LEHMANN: More police protection?

6 MR. LAPRES: Well, if you call it that,  
7 police powers.

8 DR. LEHMANN: Police powers.

9 MR. LAPRES: That's all I wanted to say.  
10 I did have a couple of questions I wanted to direct to  
11 you if I might take a moment to do that. I am intrigued  
12 by the proposition that trafficking in drugs should be  
13 illegal, and, at the same time, the possession of a drug  
14 should be authorized; should be permitted. And I was  
15 wondering if you might take a moment --- I don't know if  
16 other people in the audience know the answer to this  
17 question, or are interested in it, but I know I am  
18 certainly interested.

19 THE CHAIRMAN: Well, we have said what  
20 we can say on that in the interim report. I don't know  
21 that we should attempt to elaborate on that now. We  
22 don't want a series of interim reports. I don't know  
23 that we can add anything really to what we said there.  
24 Have you read what we have said in the interim report?

25 MR. LAPRES: No sir, I haven't.

26 THE CHAIRMAN: I suggest you get the  
27 Interim Report and as a matter of fact we probably have  
28 a copy here.

29 MR. LAPRES: I will do that.

30 THE CHAIRMAN: And by all means communicate



1 with us further, and if there is anything we can do --  
2 but we have said what we could at that time in that  
3 matter and it was in the nature of tentative conclusions  
4 and recommendations, and we also stressed that.

5 MR. LAPRES: All right.

6 THE CHAIRMAN: Thank you very much for  
7 your assistance.

8 Yes?

9 THE PUBLIC: Members of the Commission,  
10 I have a very, very brief report, but if you are too  
11 weary I can submit that ---

12 THE CHAIRMAN: We are not weary.

13 THE PUBLIC: Today we are living in  
14 times of great stress and strain. In this era of  
15 instant communication we hear much about the medical  
16 use of drugs, and also the non-medical use of  
17 drugs. In reference to the non-medical use of drugs,  
18 there are those who would advocate legislation in favour  
19 of the sale and use of marijuana. What good would this  
20 do? What purpose would it serve? Even the experts  
21 cannot assure us that marijuana is harmless. Research  
22 done to date has not been able to produce any  
23 conclusive evidence for or against this drug. Two of  
24 our most widely used drugs socially today are known to  
25 produce harmful effects.

26 Alcoholism is recognized as our number  
27 one social problem. Our number four health problem.  
28 Tobacco, as we know, is equally harmful, yet both are  
29 accepted and used freely.

30 Let us not make another mistake in



1 legalizing marijuana. I urge this Commission not to be  
2 too hasty in making a decision which in years to come  
3 may prove regrettable. If we are to maintain and build  
4 this democratic society in Canada which we see being  
5 threatened by a vociferous minority lately, we as  
6 and  
7 parents, teachers, /educators in any form must provide  
8 more for our youth than this.

9 As an alternative, greater efforts must  
10 be made at all levels of government and society to  
11 eliminate the social ills which create an environment  
12 to using these drugs as a crutch. I, as a parent, and  
13 having had background as a pharmacist do not wish nor  
14 believe this law would serve any useful purpose.

15 In closing, I would like to comment on a  
16 very excellent article in today's paper by Dr. Franz  
17 E. Winkler. He is an eminent international authority  
18 on the subject of marijuana.

19 "Since  
20 /my main interest in medicine happens to  
21 be the health of the personality as a whole,  
22 I have tried for 38 years to make friends  
23 with young children and to keep their  
24 confidence and friendship through their  
25 adolescent and adult years. Among them  
26 there are those who have taken marijuana  
27 at one time or another, giving me a chance  
28 to observe its effects on the deeper strata  
29 of the personality, strata well hidden  
30 from a casual observer. In this long  
experience, I have come to the conclusion  
that the abuse of marijuana is one of the  
major tragedies of our time".

"What makes the use of marijuana tragic  
is that it appeals not only to the  
neurotic and already defeated but to  
healthy young people who seek in it nothing  
worse than diversion or an expansion of  
consciousness".

Thank you for giving us this opportunity.

THE CHAIRMAN: Thank you.





1                   The gentleman there?

2                   THE PUBLIC: My name is Henry Reardon,

3 and I am a medical doctor, a family practioner in the

4 metropolitan area of Halifax. I am here today not

5 because of any specialized knowledge I have

6 this problem, but rather because of the great ignorance

7 I have of this problem, and have had up until today.

8 And while I still have a lot of ignorance, I am

9 much more aware of the problem than I was before I came

10 in here. I think in all my 25 years of practice, that

11 up until the last couple of years we have been able to

12 pretty well adequately handle the problems that come

13 before us. The facilities in the area for consultation

14 in the field where the general practioner can be expected

15 to know everything are adequate. Whether it be surgical

16 or medical or other type of problems. In the past few

17 years we have become more familiar with the area of

18 the drug problem, where the facilities are not only

19 inadequate, they are almost non-existent to help the

20 family practitioner with the drug problem when he is

21 dealing with the whole strata. Many people have spoken

22 about the drugs and all of these things, but I have

23 heard nobody speak on the effects of the whole family,

24 people other than the drug user himself. I have found

25 nothing in my 25 years of practice that has disturbed me

26 as much as the experience I have had over the past two

27 years with the drug users. I have had a large experience

28 with alcoholics when I started practice 25 years ago.

29 There were few doctors around who would look after

30 alcoholics and being a new member of the medical



1 profession, I got a lot of them, and I got most of the  
2 calls between 12:00 at night and 6:00 in the morning,  
3 much like the young lawyer who gets all of the legal aid  
4 work when he first starts in. I found very few alcoholics  
5 that at some stage of the game I could not reach. I  
6 found very few drug takers among the younger age groups  
7 that I am able to reach. This concerns me tremendously.  
8 I say to myself, "What is the problem, is it just my  
9 dismal ignorance of the drugs, is it the fact that in  
10 the middle of the afternoon in my office I just have not  
11 the time to sit down and talk to these young people and  
12 give them the help that I should be able to do?" There  
13 are not enough hours in the day. There are not enough  
14 people in this area doing general practice to allow a  
15 busy family practitioner the time that he adequately needs  
16 to be of any meaningful help to a drug addict, or a  
17 child who is afflicted with the drug problem, whether  
18 they are starting and looking for help, or whether they  
19 are deeply into the habit, and looking for help. I am  
20 concerned at what happens if these drugs are legalized.  
21 We have a problem today. We have drugs with us whether  
22 we like it or whether we don't like it. They are here  
23 and the problem has to be faced. There is no question,  
24 I think, that if marijuana is legalized, that our problem  
25 is going to become boundless. We have not the facilities  
26 today, trained help today to look after the problem we  
27 have. If the legalization of drugs takes place any time  
28 soon, we will have complete chaos in the treatment of  
29 these people who need help. Now, I think that one of the  
30 decisions, and certainly the recommendations of this



1 committee and responsibilities of this committee, is not  
2 so much whether drugs should be legalized or remain as  
3 they are, but what is the responsibility of any Government  
4 towards seeing that the people that have the problems  
5 today have an opportunity of help with these problems  
6 if they so desire. We haven't in this province proper  
7 facilities for looking after our mentally retarded, and  
8 they have been with us for a long time. We have not  
9 the proper facilities for our alcoholics, and they have  
10 also been with us for a long time. We have even less  
11 facilities for looking after our drug problem. Now,  
12 appalled as I am over my inadequacy in this field, I am  
13 more appalled today when I look around the hall, to see  
14 the lack of the number of parents of children with drug  
15 problems that are not here. There are not as many  
16 parents here today as I have parents with children with  
17 drug problems. If they are concerned about their  
18 children as they make believe when they are at my office,  
19 they should be at this type of meeting, expressing their  
20 views and their opinions, and getting after the  
21 authorities to see that something is done to help them  
22 with their difficulties. Alcoholics cause a lot of  
23 upheaval in families. There is no question about that.  
24 But in families where there is a drug problem, we have  
25 not only the fathers and the mothers fighting, we have  
26 the mothers fighting with the children, and children  
27 fighting with the mothers, and vice versa. Everybody  
28 is fighting among everybody else. The result is that  
29 not only the drug user leaves home, but the father  
30 leaves the rest of the family or the mother leaves the





1 rest of the family, or the other kids if they are able,  
2 and old enough to get out and away from the surroundings.  
3 The disruption in a family in which there is a drug  
4 user is far greater than in a family where the mother or  
5 the father is an alcoholic. To me, as a firstsource, as  
6 a family doctor, to me it is a problem because there is  
7 not enough time in the day because I cannot find enough  
8 time or a place to refer my drug problems, where they  
9 will be looked after. My report comes back that there  
10 is nothing you can do for this type of habit. We have  
11 no hospital facilities where they --- I should not say  
12 we have no hospital facilities, that is not so. We have  
13 some of the best hospital facilities in the world here  
14 for the treatment of most of our problems, but we have  
15 no hospital facilities, not enough hospital beds where  
16 we can admit our drug takers with medical problems  
17 quickly enough to get them prompt enough help. And  
18 this, to my mind, is something that must be dealt with  
19 by any Commission and it should be reported to any  
20 Government, that there must be adequate help for people  
21 who do have the difficulty. Some people take drugs and  
22 do not have a problem. That is obvious from the people  
23 who spoke here today. Other people take drugs, and are  
24 in great difficulty. And we have heard today from the  
25 gentleman who got up and talked about his history of  
26 taking speed for two years, and then he said that  
27 people who took speed are not crazy or stupid. I don't  
28 know. But after listening to him, I do not know, and  
29 I think there is doubt for his conclusion. And my problem  
30 today --- and I am delinquent today in that I left my



1 office just as the high school students left their  
2 classrooms today -- is that when you make a law to  
3 legalize drugs, it will be legalized across the country,  
4 and if marijuana is legalized, it is not going to create  
5 the same problem in British Columbia and Ontario as it  
6 does in Nova Scotia. They will have the facilities or  
7 the money available to treat the people who are in  
8 difficulty, but in Nova Scotia and the other Atlantic  
9 provinces and some of the western provinces, it is  
10 going to be a problem, because there is just not enough  
11 money available and time available to get adequate  
12 facilities quickly enough to look after this problem.  
13 Many of the problems we have here, they do not have in  
14 some of the richer provinces. But the problem will be  
15 here, whether we are poor or whether we are rich, and  
16 whoever decides that the problem is too multiplied and  
17 compounded must also be prepared to help us pay with a  
18 share in looking after the results of these laws.

19 THE CHAIRMAN: Thank you very much, Dr.  
20 Reardon. Are there any questions for the Doctor, Dr.  
21 Reardon.

22 MR. CAMPBELL: Is there any type of  
23 programme you would like to see initiated, Doctor, or  
24 would you need any more training?

25 DR. REARDON: I think the thing we need  
26 and I don't think there is anyone that could give us  
27 more time in the day. We need more medical practitioners  
28 doing general practice. Every day we are having fewer  
29 in the field of general practice. Our medical training  
30 is such that it is not orientated to general practice,



the training  
1 and/in the past 25 years has not been orientated towards  
2 drug addiction and so forth. When I was a student and  
3 when I first started practice, sure, we ran into people  
4 who were addicted to morphine and seconal and the other  
5 barbiturates and so forth, but up until a few years ago  
6 I don't think I saw a person addicted to other drugs,  
7 and I have been busy over the year, and that is what is  
8 to my mind the most frustrating to all of us who have  
9 this problem thrust upon us, for which we are just not  
10 trained to handle. And what is even more frustrating  
11 is that there is nobody in this area that is trained to  
12 handle it. And it is not a simple problem like if you  
13 get somebody with a sore throat. You can see that  
14 patient; you can look at him, you can treat the sore  
15 throat, and it takes you five minutes or less. But to  
16 sit down and adequately treat a person with a drug  
17 problem, they take you five hours or more. Now, there is  
18 no person, no doctor, who is in the practice of medicine  
19 with the hours that we have to work, who can sit down  
20 and try to help a patient for three or four hours if  
21 you had half a dozen of those patients. These kids are  
22 in trouble a lot. The drug taking is often just something  
23 that has come on because of the other background problems  
24 they have, and we have to take time to find out what  
25 these background problems are. I think if we are going  
26 to set up something to help these people who are in  
27 trouble with drugs, we have to have a new type of help;  
28 a new type of doctor, if you will, that has the time and  
29 is paid for spending that time, to do nothing else  
30 than to try and give these people the help they need.





1 Now there is no one doctor in the world that can do all  
2 of this. It is going to have to be a key method in  
3 which there may be family physicians and specialists  
4 of various kinds, medical, pediatric, psychiatric and  
5 psychologists. I can see no one person who can adequately  
6 treat this problem all by himself.

7 DR. LEHMANN: Dr. Reardon, what you are  
8 saying then, is the problem is really troubled youth,  
9 which is overwhelming society now, and that there ought  
10 to be more help provided. And as you know, as I am  
11 quite sure, the difficulties are tremendous even to  
12 fill the purely medical needs of the community now,  
13 so there is a great deal, or a great move on now to  
14 have paramedical personnel to take over, because no  
15 physicians in North America can be expected to fill  
16 the needs, purely medical sore throat needs. Now, the  
17 others take much more time and many, many  
18 The juvenile delinquency, the troubled youth in general,  
19 drugs being one of the problems only. And certainly,  
20 there is a great need to find these people. But can  
21 you foresee to train all of the physicians, and all of  
22 the psychologists and all those specialists, pediatricians,  
23 and  
/psychiatrists who would be necessary for this, overnight?

24 DR. REARDON: We may never reach the  
25 optimum in anything, but certainly we can try to  
26 increase the forces that we presently have which are  
27 wholly inadequate, to get a force that will perhaps  
28 not get optimum, and not completely adequate, but  
29 certainly better than what we have today. We are  
30 wasting a lot of our medical personnel. We have got



1 medical doctors sitting down day after day after day  
2 doing nothing but administrative work. They go through  
3 seven, eight, nine or ten years of training and then  
4 sit behind a desk somewhere and become an armchair  
5 physician. Those are the type of people that you want  
6 to replace by paramedical personnel and put the doctors  
7 back to work, not behind a desk doing administrative  
8 problems that anybody can do. That would also help the  
9 problem of help to the community.

10 THE CHAIRMAN: Thank you very much,  
11 Doctor.

12 I should like to, in closing this  
13 hearing, thank everyone for your assistance that we  
14 have received today. It has been a very full day and  
15 for us a very informative day. We have received a great  
16 deal of assistance in our work from this part of the  
17 country and we are very grateful for it. Thank you, all.

18 --- Upon adjourning at 6 p.m.  
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